INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Financial Transactions and Remittance Advice

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Revision History

Version	Date	Reason for Revisions	Completed By
1.0	Policies and procedures as of October 1, 2015 Published: February 25, 2016	New document	FSSA and HPE
1.1	Policies and procedures as of August 1, 2016 (*Core*MMIS updates as of February 13, 2017) Published: April 6, 2017	Scheduled update	FSSA and HPE
2.0	Policies and procedures as of September 1, 2017 Published: December 12, 2017	Scheduled update	FSSA and DXC
3.0	Policies and procedures as of October 1, 2018 Published: January 15, 2019	Scheduled update	FSSA and DXC
4.0	Policies and procedures as of November 1, 2019 Published: February 27, 2020	Scheduled update: • Edited text as needed for clarity • Updated the initial note box with standard wording • Added the *Viewing Payment History and RAs via the Portal* section • Changed dental claim form references from *ADA 2006* to *ADA 2012* • Updated the document references in the *Comparison of the 835 Transaction and Remittance Advice* section	FSSA and DXC

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Financial Transactions and Remittance Advice

> *Note: The procedures in this document pertain to **nonpharmacy** services provided within the **fee-for-service** (FFS) delivery system. Questions about financial transactions related to FFS **pharmacy** services should be directed to OptumRx. Questions about financial transactions related to services provided within the **managed care** delivery system should be directed to the member's managed care entity (MCE). MCE and OptumRx contact information is available in the IHCP Quick Reference Guide at in.gov/medicaid/providers.*
>
> *For updates to the information in this module, see IHCP Banner Pages and Bulletins at in.gov/medicaid/providers.*

Introduction

The most significant tool the Indiana Health Coverage Programs (IHCP) provider has to monitor participation in the program is the weekly Remittance Advice (RA). The RA statement provides information about claim processing and financial activity. To assist providers in using this tool, this document provides a copy of an RA with a detailed description of each field.

In addition to claim adjudication, a variety of transactions unrelated to a particular claim affects providers. These transactions are referred to as *non-claim-specific* financial transactions. This document outlines the different transactions, how each transaction is handled, and where the transaction appears on the weekly RA. This document also includes information about the following topics:

- Electronic funds transfer (EFT)
- Stop payments and reissuance of IHCP checks
- Voids of IHCP checks
- Accounts receivable (A/R)
- Internal Revenue Service (IRS) reporting requirements

Provider Remittance Advice

The IHCP financial cycle runs every Friday. Payments are calculated based on paid claims, less payments for outstanding accounts receivable and liens. Check payments are dated for the Wednesday following the financial cycle. EFT payments are deposited to the provider's designated bank account each Wednesday following the financial cycle.

RA statements about the status of processed claims and payment details are available to providers via the IHCP secured website, the Provider Healthcare Portal (Portal), accessible from the home page at in.gov/medicaid/providers. The Portal posts the weekly RA online after the financial cycle processes. Providers should access the Portal each week to download and save RAs for review. RAs from February 21, 2017, to the current RA are stored on the Portal and available for review at any time. See the *Viewing Payment History and RAs via the Portal* section for instructions.

Providers that want to receive a printed copy of an RA by mail can submit a request to the Written Correspondence Unit, either on their letterhead or using the *Indiana Health Coverage Programs Written Inquiry* form, available on the *Forms* page at in.gov/medicaid/providers. The cost for a paper RA is $0.15 a page. The provider must first call Customer Service, check the Portal, or submit a written request (by mail or using Portal secure correspondence) to determine the total number of pages. The provider then sends a check for the full amount, made out to **DXC Technology**, along with their request for the paper RA, to the following address:

DXC Written Correspondence
P.O. Box 7263
Indianapolis, IN 46207-7263

To receive RA information through the 835 Health Care Claim Payment/Advice electronic transaction, providers are required to complete the necessary trading partner profiles and agreements. Providers can enroll for the 835 transaction on the Portal (**My Home** > **Provider Maintenance** > **ERA Changes**). For more information about the 835 transaction, the *835 Implementation Guide* is available for purchase and download through the Washington Publishing Company website at wpc-edi.com. In addition, a companion guide for the 835 transaction is available from the *IHCP Companion Guides* page at in.gov/medicaid/providers. See the *Electronic Data Interchange* module for information about becoming an IHCP trading partner.

Viewing Payment History and RAs via the Portal

> *Note: See the Provider Healthcare Portal module for general information about registering for and using the Portal.*

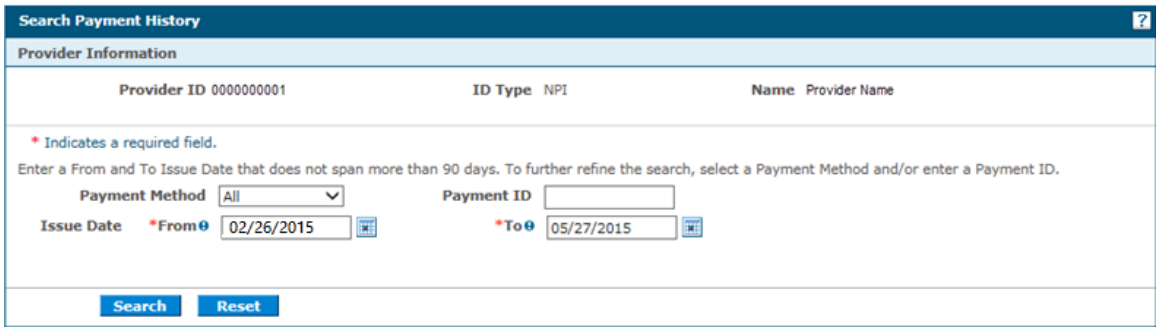
Providers (and their delegates with appropriate permissions) can log into the Portal to view electronic funds transfer (EFT), check-payment, and zero-pay-payment records for claims, as well as to view and download the associated Remittance Advice (RA).

RAs on the Portal show all FFS, nonpharmacy activity involved with a given week's payment. You can search through an RA to see if a specific claim has been paid, suspended, or denied. Adobe Acrobat Reader is required to open and view RA documents in the Portal.

Follow these steps to search payment history, view payment details, and view and download PDF copies of RAs on the Portal:

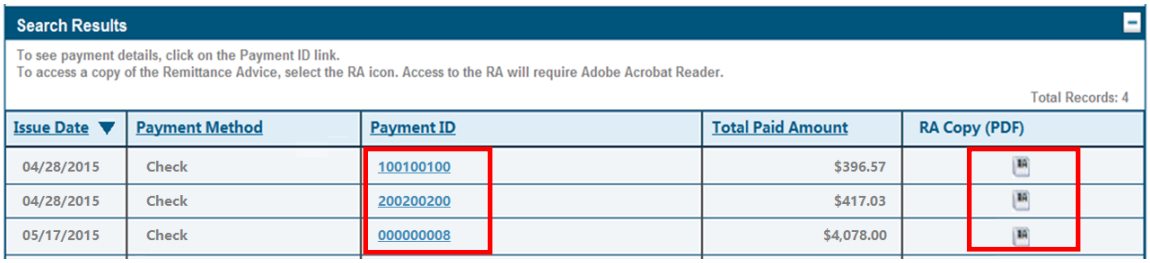
1. From the Portal menu bar, select **Claims > Search Payment History**.
2. In the *Search Payment History* panel, add or adjust the search criteria as desired:
   - The Issue Date fields automatically populate with the date of the search (today) in the To field and 90 days prior to today's date in the From field. You can narrow the date range to show fewer search results.
   - You can also narrow search results by payment method and/or payment ID.
3. After you have entered all the desired search parameters, click **Search**.

Figure 1 – Search Payment History



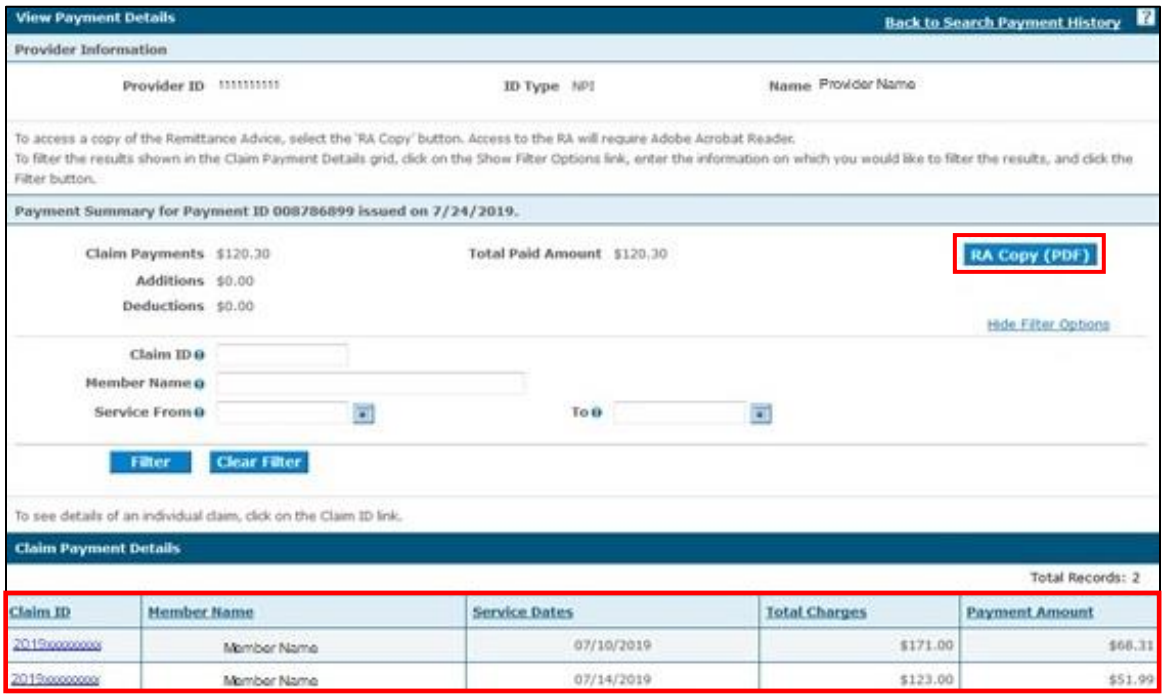
4. View search results to locate the desired payment:
   – Any claims that fall within the desired search parameters are displayed in the *Search Results* panel.
   – You can sort search results by clicking any of the underlined column names. The arrow next to the column name indicates whether the results are displayed in ascending or descending order. The example in the following figure shows the search results sorted in descending order by issue date.

Figure 2 – Payment History Search Results



5. To access and view the RA for a payment, click the RA icon in the **RA Copy (PDF)** column for that payment.
6. To view details about a specific payment, click the corresponding link for that payment in the **Payment ID** column to open the *View Payment Details* page.

Figure 3 – View Payment Details (with Payment Summary Filter Options)



7. View information about claims associated with the selected payment, as follows:
   - Scroll through the list in the *Claim Payment Details* panel to view the Claim ID, member name, service dates, total charges, and payment amount for all claims associated with the payment.
   - If desired, use filter options in the *Payment Summary…* section to narrow the list to a specific claim number, member name, or service date range.
   - Click the Claim ID link for any claim in the list to view the associated claim.
8. To access and view the RA for the payment (if not done in step 5), click **RA Copy (PDF)**.

Remittance Advice Overview

RAs provide information about in-process claims, suspended claims, and adjudicated claims that are paid, denied, or adjusted. The RA reports claim activity only for each specific week. The RA also provides information about other processed financial transactions.

The RA is an important provider payment and claim-tracking device. Providers should reconcile claim transactions as soon as possible after receiving the RA statement. RA pages outline claim data in the following two ways:

- Header (claim level) information that applies to the entire claim
- Detail (service-line level) information that refers to a single line

Each RA section, such as *Claims Paid* or *Claims in Process*, totals the information after the last claim entry in that section. In addition, the RA *Summary* page includes data about individual sections. Information on the RA is standardized, as much as possible, for all claim types.

This document describes RAs from a general perspective and provides RA field definitions. For specific questions about an RA statement, refer to the explanation of benefits (EOB) and adjustment reason code (ARC) descriptions at the end of the RA.

> *Note: The unique number assigned to each claim, referred to as the **Claim ID** on the Portal, is identified on the RA as **ICN** (for internal control number).*

Remittance Advice Section Descriptions

The RA displays transactions in the following order:

- *Claims Paid*: This RA section shows claims with a paid status, including claims paid at zero. An example of a zero-paid claim is a claim for a member with other insurance, when the other insurance paid an amount equal to or greater than the IHCP allowable amount.
- *Claims Denied*: This RA section shows the same basic information as for paid claims. The IHCP denied payment for these claims.
- *Claims in Process*: This RA section lists claims in the processing cycle that have not been finalized. This section includes claims that have attachments, claims that are past the filing limit, claims that require manual pricing, claims for voids and replacements that have not been finalized, and suspended claims. **The IHCP has not denied these claims.** The EOB, ARC, and adjustment remarks provided with the in-process claim provide information as to why the claim has not yet been processed. Claims reflected as in process are resolved as paid, denied, or adjusted on subsequent RAs. Providers must monitor claims in process to final resolution. Claims in suspense appear in the RA only for the week in which they are **first** suspended.

> *Note: Each claim in process lists the EOB message that corresponds to the reason it has been suspended.*

- *Claim Adjustments*: This RA section lists adjusted claims, also known as *voids and replacements*. Each adjusted claim shows two header lines. The first header line is for the original claim, and the second header line is for the replacement claim. If an already-adjusted claim requires additional adjustment, the last ICN/Claim ID assigned becomes the original claim to become adjusted.
- *Payment Hold:* This RA section lists all ICNs/Claim IDs whose payment is on hold.
- *Medical Education Cost Expenditures:* This RA section lists all encounter claim adjustments that were paid for medical education.
- *Financial Transactions*: This RA section lists the provider-level adjustments, which includes non-claim-specific payouts, refunds, and A/R transactions. The IHCP uses a transaction number to uniquely identify each financial transaction. If a financial transaction is associated with a cash receipt, then the cash control number (CCN) displays. All financial transactions identify an adjustment to net payment, either positive or negative. Examples of miscellaneous financial transactions tabulated in this RA section include the following:
  - Refunds made by a provider that exceed the original claim payment. *Core*MMIS generates a payout to return the over-refunded amount to the provider.
  - Adjusted claim resulting in a negative balance, which creates an A/R.
  - Amounts scheduled for recouping. The A/R offset section tracks the repayment of the amount to be recouped.
- *EOB Code Descriptions*: This RA section lists EOB codes applied to submitted claims, along with the respective code narrative. These codes and corresponding narratives describe the reasons submitted claims are adjusted, suspended, or denied or did not pay in full. The order of the description list is numeric for EOB codes 001 to 9999.
- *Adjustment Reason Code Descriptions*: This RA section lists the ARCs and their respective code narratives that reflect the adjustments in payment, between the billed amount and the allowed or payment amounts, applied to submitted claims at the claim level or the service-line level. The order of these codes and corresponding narratives is numeric, then alphanumeric.

- *Service Code Descriptions:* This RA section lists all procedure and/or revenue codes that appear on the RA and provides corresponding descriptions.
- *Remark Code Descriptions:* This RA section lists all remark codes that appear on the RA and provides corresponding descriptions.
- *Summary*: This page reflects data from the entire RA series. This page summarizes all claim and financial activity (provider-level adjustments) for each weekly cycle and reports year-to-date totals. In addition, the report provides information about lien payments made to external lien holders during the current payment or financial cycle and year-to-date. The *Summary* page also reports capitation payments (for managed care entities only).

The 835 transaction reports claims by ICN/Claim ID. For a specific provider, all the claims are sorted by ICN/Claim ID and reported together, followed by any provider-level adjustments.

Remittance Advice Claim Sorting Sequence

Claims are shown on the RA by type and according to the following priority sequence:

- *CMS-1500* claim form/Portal professional claim/837P transaction
  - Alphabetically by member name
  - Numerically by ICN/Claim ID
- *UB-04* claim form/Portal institutional claim/837I transaction
  - Alphabetically by member name
  - Numerically by ICN/Claim ID
- *ADA 2012* claim form/Portal dental claim/837D transaction
  - Alphabetically by member name
  - Numerically by ICN/Claim ID

Crossover claim data appears first on the RA and follows the priority sequence per claim type.

The 835 electronic transaction sorts claims in the following sequence:

- Trading partner identification
- Billing National Provider Identifier (NPI)
- ICN/Claim ID

Remittance Advice Field Definitions

Table 1 lists the RA fields in alphabetic order. Each field name is preceded by a number that corresponds to where the field appears in Figures 4 to 21. Where applicable, slight variations in field names (depending on the RA type or section in which the field appears) also appear in Column 1. Column 2 includes a description of the information contained within that field. Column 3 indicates in which RA section the field may appear and, where applicable, on which type of RA. In addition, for some fields, Column 4 of the table includes a description of how the information appears on the electronic 835 transaction.

> *Note: Not all fields appear on each section of the RA. Many fields are specific to the claim type being billed.*

Table 1 – Provider Remittance Advice Fields

Field Name	Description	RA Section (and Claim Type)	835 Transaction Information
1 ADDITIONAL PAYMENT	Additional amount owed to a billing provider as the result of a claim adjustment.	*Claim Adjustments*	
2 ADJUSTMENT ICN	Unique identifier (ICN/Claim ID) of the adjusted claim that resulted in the creation of an accounts receivable.	*Financial Transactions – Accounts Receivable*	
3 ADMIT DATE ADMIT DT	Date the member was admitted to a hospital.	*Claim Adjustments*, *Claims Paid*, *Claims Denied*, *Claims in Process* (Inpatient and Medicare Crossover Institutional)	
4 AMOUNT HELD	The amount payable for a transaction being held from payment due to a payment hold request.	*Payment Hold*	
5 AMOUNT RECOUPED IN CURRENT CYCLE	Total amount recouped during the current financial cycle.	*Financial Transactions – Accounts Receivable*	PLB04
6 A/R NUMBER	Unique number assigned to each account receivable setup in the financial system.	*Financial Transactions – Accounts Receivable*	PLB03-2
7 ARC CODE / DESCRIPTION	A list of all Adjustment Reason Codes (ARCs) that appear on the RA, and the text description for each code.	*ARC Code Descriptions*	
8 ARCS	Adjustment Reason Codes (ARCs) that apply to the claim. There could be a maximum of 20 ARC codes. The 00 ARC line corresponds with the claim header. The 01–999 lines correspond with each detail.	*Claim Adjustments*, *Claims Denied*, *Claims Paid*, and *Claims in Process*	• CAS claim level if the line number is 0 • CAS service level if the line number is 1 through 450
9 AREA OF ORAL CAV	Quadrant of the mouth where dental services were performed.	*Claim Adjustments*, *Claims Denied*, *Claims Paid*, and *Claims in Process* (Dental)	

Field Name	Description	RA Section (and Claim Type)	835 Transaction Information
10 ALLOWED AMOUNT ALLOWED AMT *[Header level]*	Computed dollar amount allowable by Medicaid for the claim. A header allowed amount represents only amounts applied to the header portion of the claim.	*Claim Adjustments* and *Claims Paid*	
11 ALLOWED AMT *[Detail level]*	Computed dollar amount allowable by Medicaid for each detail item billed.	*Claim Adjustments* and *Claims Paid*	AMT02
12 ALLOWED AMT *[Medicare]*	Amount that was allowed by Medicare for the services.	*Claim Adjustments*, *Claims Denied*, *Claims Paid*, and *Claims in Process* (Medicare Crossover Professional Service)	
13 ALLW UNITS	Units of service allowed for the detail.	*Claim Adjustments*, *Claims Denied*, *Claims Paid*, and *Claims in Process*	SVC05
14 BALANCE	Amount outstanding for the accounts receivable.	*Financial Transactions – Accounts Receivable*	PLB segment • If the A/R was created in the current financial cycle, the PLB segment contains the amount of A/R or the amount recouped in this cycle. • If the A/R was created in a previous financial cycle, the PLB segment contains the balance remaining on the A/R or the amount recouped in this cycle.
15 BILLED BILLED AMT BILLED AMOUNT *[Header level]*	Amount requested by the provider for the claim. The header billed amount is arrived at by adding the detail billed amounts on all the detail lines.	*Claim Adjustments*, *Claims Denied*, *Claims Paid*, and *Claims in Process*	CLP03
16 BILLED AMT BILLED AMOUNT *[Detail level]*	Amount requested by the provider for the item billed on each detail line.	*Claim Adjustments*, *Claims Denied*, *Claims Paid*, and *Claims in Process*	SVC02

Field Name	Description	RA Section (and Claim Type)	835 Transaction Information
17 BLOOD DEDUCT *[Medicare]*	Amount of money paid toward the blood deductible on a Medicare Crossover claim.	*Claim Adjustments*, *Claims Denied*, *Claims Paid*, and *Claims in Process* (Medicare Crossover Institutional)	
18 C DAYS	Number of days the member was in the hospital.	*Claim Adjustments*, *Claims Denied*, *Claims Paid*, and *Claims in Process* (Inpatient)	
19 CO-INS *[Medicare]*	Amount that the member should pay and is deducted from the allowed amount to arrive at the Medicare paid amount.	*Claim Adjustments*, *Claims Denied*, *Claims Paid*, and *Claims in Process* (Medicare Crossover Institutional and Medicare Crossover Professional Service)	
20 CO-INS CB	The coinsurance cutback amount that the member is responsible for paying. This amount is subtracted from the allowed amount to arrive at the paid amount.	*Claim Adjustments* and *Claims Paid*	
21 COND CODE	Condition code identifies conditions relating to this bill that may affect payer processing.	*Claim Adjustments*, *Claims Denied*, *Claims Paid*, and *Claims in Process* (Long Term Care)	
22 COPAY AMT *[Detail level]*	Amount of member responsibility on a claim detail that is to be collected by the provider at the time the service is rendered.	*Claim Adjustments* and *Claims Paid*	
23 COPAY AMT *[Header level]*	Amount of member responsibility on a claim that is to be collected by the provider at the time the service is rendered. A header copay amount represents only amounts applied to the header portion of the claim.	*Claim Adjustments* and *Claims Paid*	

Field Name	Description	RA Section (and Claim Type)	835 Transaction Information
24 COPAY AMT *[Medicare]*	Amount of member responsibility on a Medicare claim that is to be collected by the provider at the time the service is rendered. Medicare copay may be paid by Medicaid.	*Claim Adjustments*, *Claims Denied*, *Claims Paid*, and *Claims in Process* (Medicare Crossover Institutional and Medicare Crossover Professional Service)	
25 DAYS	Number of days the member was in the hospital.	*Claim Adjustments*, *Claims Denied*, and *Claims Paid* (Long Term Care and Medicare Crossover Institutional)	
26 DEDUCT *[Medicare]*	Amount that the member is responsible for paying. This dollar amount will crossover and be paid by Medicaid.	*Claim Adjustments*, *Claims Denied*, and *Claims Paid* (Medicare Crossover Institutional and Medicare Crossover Professional Service)	
27 DRG CD	Diagnosis-Related Group (DRG) is the system used to classify hospital cases into one of approximately 500 groups, also referred to as DRGs, expected to have similar hospital resource use, developed for Medicare as part of the prospective payment system. DRGs are assigned by a "grouper" program based on ICD diagnoses, procedures, age, sex, and the presence of complications or comorbidities.	*Claim Adjustments*, *Claims Denied*, *Claims Paid*, and *Claims in Process* (Inpatient)	CLP11
28 EOBS	Explanation of Benefits (EOB) codes that apply to the claim. There could be a maximum of 20 EOB codes. The 00 EOB line corresponds with the claim header. The 01 and the subsequent EOB lines correspond with each detail.	*Claim Adjustments*, *Claims Denied*, *Claims Paid*, and *Claims in Process*	Not applicable EOB codes are IHCP-specific and cannot be written to the 835 transaction. Only national standard X12 835 ARC and remark codes are written to the 835 transaction.

Field Name	Description	RA Section (and Claim Type)	835 Transaction Information
29 EOB CODE/ DESCRIPTION	The Explanation of Benefits (EOB) code or the Adjustment EOB code and text description. The Adjustment EOB code is the 4-digit code on a claim adjustment that indicates the reason for the adjustment.	*EOB Code Descriptions*	
30 FIN ARC	Adjustment reason codes (ARCs) that apply to the financial transaction.	*Financial Transactions*	PLB segment for provider-level adjustments
31 ICN	Internal control number (ICN), which uniquely identifies a claim. (On the Portal, this number is referred to as the *Claim ID*.)	*Claim Adjustments*, *Claims Denied*, *Claims Paid*, and *Claims in Process*	CLP07
32 INPAT DED INPAT/OUTPAT DED	One time set annual cost to the member. Displays how much of the claim paid amount was cut back due to this specific deductible.	*Claim Adjustments* and *Claims Paid* (Inpatient and Medicare Crossover)	
33 MED ED AMT MEDICAL ED AMT	Amount of medical education cost paid during the current financial cycle.	*Medical Education Cost Adjustments* and *Medical Education Cost Expenditures*	
34 MEMBER NAME	Name of the member identified on the claim.	*Claim Adjustments*, *Claims Denied*, *Claims Paid*, and *Claims in Process*	• Last name: NM103 • First name: NM104 • Middle initial: NM105
35 MEMBER NO.	Unique IHCP identifier of the member, referred to on the Portal as Member ID (formerly known as RID).	*Claim Adjustments*, *Claims Denied*, *Claims Paid*, and *Claims in Process*	NM109 using qualifier code QC
36 MODIFIERS	Code used to further describe the service rendered. Up to four modifiers may be entered on each detail line.	*Claim Adjustments*, *Claims Denied*, *Claims Paid*, and *Claims in Process*	SVC01-3, SVC01-4, SVC01-5, and SVC01-6
37 MRN	The unique medical record number (MRN) assigned by the provider. This number is usually used for filing or tracking purposes.	*Claim Adjustments*, *Claims Denied*, *Claims Paid*, and *Claims in Process*	

Field Name	Description	RA Section (and Claim Type)	835 Transaction Information
38 NPI	Billing provider National Provider Identifier (NPI). If the NPI has not been reported to the IHCP, this field is blank. For atypical providers, this field is always blank.	All RA sections on all RA types	N104 N103 has a qualifier code of XX. If the NPI is not known, the F1 qualifier is in N103, and the billing provider federal tax ID is in N104.
39 ORIGINAL AMOUNT	Setup amount of the accounts receivable.	*Financial Transactions – Accounts Receivable*	PLB segment • If the A/R was created in the *current* financial cycle, then the amount the A/R was created for or the amount recouped in this cycle will be written to the PLB segment. • If the A/R was created in a *previous* financial cycle, then the balance remaining on the A/R or the amount recouped in this cycle will be written to the PLB segment.
40 OTH INS AMOUNT OTH INS AMT	Dollar amount paid for the services by any source outside the IHCP, including Medicare.	*Claim Adjustments*, *Claims Denied*, *Claims Paid*, and *Claims in Process*	
41 OUTLIER AMT	Any reimbursable amount, in addition to the hospital diagnosis-related group (DRG) rate, for certain inpatient stays that exceed established cost thresholds associated with the hospital stay.	*Claim Adjustments*, *Claims Denied*, *Claims Paid*, and *Claims in Process* (Inpatient)	
42 OUTPAT DED	One-time, set annual cost to the member. Displays how much of the claim paid amount was cut back due to this specific deductible.	*Claim Adjustments* and *Claims Paid* (Outpatient, Professional Service, and Medicare Crossover Professional Service)	
43 OVER-PAYMENT TO BE WITHHELD	Additional amount owed by a billing provider as the result of a claim adjustment. If this amount cannot be recovered in the current cycle, an accounts receivable record is generated.	*Claim Adjustments*	

Field Name	Description	RA Section (and Claim Type)	835 Transaction Information
44 PAID AMOUNT PAID AMT *[Detail level]*	Amount that is payable for the claim detail.	*Claim Adjustments* and *Claims Paid*	SVC03
45 PAID AMOUNT PAID AMT *[Header level]*	Amount that is payable for the claim.	*Claim Adjustments* and *Claims Paid*	CLP04
46 PAID AMT *[Medicare]*	Amount that was paid under Medicare for the services/ hospitalization stay.	*Claim Adjustments*, *Claims Paid*, and *Claims Denied* (Medicare Crossover Institutional and Medicare Crossover Professional Service)	
47 PATIENT NO. PATIENT NUMBER	The unique patient number assigned by the provider and submitted on the original claim. This number is usually used for internal tracking and control purposes.	*Claim Adjustments*, *Claims Denied*, *Claims Paid*, *Claims in Process*, and *Medical Education Cost Expenditures*	CLP01
48 PATIENT LIAB	Monthly amount the member is responsible for paying toward fees such as the long-term care facility charge. This patient liability amount is subtracted from the allowed amount to arrive at the paid amount.	*Claim Adjustments*, *Claims Denied*, *Claims Paid*, and *Claims in Process* (Home Health, Long Term Care, and Medicare Crossover Institutional)	CLP05
49 PAYEE ID	Provider ID of the entity receiving payment for goods or services. The Provider ID is a unique identification number issued by the IHCP.	All RA sections on all RA types	CLP05 • N104, if provider type = XX • REF02, if provider type = 1D
50 PAYMENT DATE	Date the checkwrite voucher is posted to the State accounting system. This is the Payment Date on the RAs and paper checks. It is not necessarily the release date of the EFT payments.	All RA sections on all RA types	BPR16

Field Name	Description	RA Section (and Claim Type)	835 Transaction Information
51 PAYMENT NUMBER	If a check was generated, the check number is listed. If the provider participates in EFT, this number is the control number of the EFT transaction.	All RA sections on all RA types	TRN02
52 PA NUMBER	Number assigned to a prior authorization (PA) request that is used for the adjudication of the claim detail.	*Claim Adjustments*, *Claims Denied*, *Claims Paid*, and *Claims in Process*	
53 PAYOUT AMOUNT	Amount of the expenditure issued to the payee.	*Financial Transactions – Non-Claim Specific Payouts to Payee*	PLB04
54 PREVIOUS ICN	Unique identifier (ICN/Claim ID) of the previously submitted claim associated to the creation of the accounts receivable.	*Financial Transactions – Accounts Receivable*	
55 PROC CD	Procedure code for services rendered. Code that identifies a medical, dental, or durable medical equipment (DME) service that is provided to the member.	*Claim Adjustments*, *Claims Denied*, *Claims Paid*, and *Claims in Process*	SVC01-2
56 PROVIDER NAME/ ADDRESS	Name and address of the provider billing for services.	All RA sections on all RA types	• Billing provider name: N102 using qualifier code PE • Billing provider address: N301 and N302 • Billing provider city: N401 • Billing provider state: N402 • Billing provider ZIP Code: N403
57 PSYCH CO-INS *[Medicare]*	Amount that the member should pay for psychiatry and is deducted from the allowed amount to arrive at the Medicare paid amount.	*Claim Adjustments*, *Claims Denied*, *Claims Paid*, and *Claims in Process* (Medicare Crossover Professional Service)	
58 REASON CODE	Identifies the reason for the account receivable setup.	*Financial Transactions – Accounts Receivable*	
59 REASON CODE	Identifies the reason for the expenditure payout.	*Financial Transactions – Non-Claim Specific Payouts to Payee*	

Field Name	Description	RA Section (and Claim Type)	835 Transaction Information
60 REASON CODE	Identifies the reason for the expenditure refund.	*Financial Transactions – Non-Claim Specific Payouts to Payee*	
61 RECEIPT DATE	System-assigned date on which a cash receipt was established in the system, manually or systematically.	*Financial Transactions – Non-Claim Specific Payouts to Payee*	
62 RECOUPMENT AMOUNT TO DATE	Total cumulative amount recovered from the associated A/R.	*Financial Transactions – Accounts Receivable*	PLB04
63 REFUND AMOUNT	Amount received from the payee and returned to the payee during this financial cycle.	*Financial Transactions – Non-Claim Specific Payouts to Payee*	PLB04
64 REFUND AMOUNT APPLIED	Amount of a cash receipt received from the provider applied to a cash-related claim adjustment.	*Claim Adjustments*	
65 RELATED PROVIDER ID	The identifier for the provider related to the expenditure, who may not be the same as the payee. For Health Information Technology (HIT) expenditures, this individual will be the Electronic Health Record (EHR)-eligible provider. For other expenditures, this could be a different related provider.	*Financial Transactions – Non-Claim Specific Payouts to Payee*	
66 REMARK CODE / DESCRIPTION	Text description for the remark code.	*Remark Code Description*	

Field Name	Description	RA Section (and Claim Type)	835 Transaction Information
67 REMARKS	Remarks report with ARCs only when they add information at the claim or service-line level.	*Claim Adjustments*, *Claims Denied*, *Claims Paid*, and *Claims in Process*	• If the line number is 0: – MOA03, MOA04, MOA05, MOA06, and MOA07 for dental, outpatient, extended care facility, home health, professional services, and Medicare Crossover Part B claims – MIA05, MIA20, MIA21, MIA22, and MIA23 for inpatient and Medicare Crossover Part A claims • If the line number is 1 through 450: – LQ02 using qualifier code HE for all claim types except drug and compound drug – LQ02 using qualifier code RX for National Council for Prescription Drug Programs (NCPDP) codes on drug and compound drug claims.

Field Name	Description	RA Section (and Claim Type)	835 Transaction Information
68 RENDERING PROVIDER	NPI of the provider that rendered a particular service; for atypical providers, the unique IHCP Provider ID is used.	*Claim Adjustments*, *Claims Denied*, *Claims Paid*, and *Claims in Process* (Dental, Professional Service, Outpatient, and Medicare Crossover)	• Claim level: – If the rendering provider is a healthcare provider, the XX qualifier is in NM108 and the NPI is in NM109. – For atypical rendering providers, the MC qualifier is in NM108 and the IHCP Provider ID is in NM109. • Service level: – If the rendering provider NPI has been reported to the IHCP, the XX qualifier is in REF01 and the NPI is in REF02. – For atypical rendering providers, the 1D qualifier is in REF01 and the IHCP Provider ID is in REF02.
69 REV CD	Revenue codes that pertain to the services being billed on a *UB-04* claim form, Portal institutional claim, or 837I transaction.	*Claim Adjustments*, *Claims Denied*, *Claims Paid*, and *Claims in Process* (Home Health, Inpatient, Long Term Care, Outpatient, and Medicare Crossover Institutional)	SVC04
70 SERVICE DATES FROM SER DT FROM *[Detail level]*	Earliest date of service or admission date for the claim detail.	*Claim Adjustments*, *Claims Denied*, *Claims Paid*, and *Claims in Process*	DTM02 • DTM01=472 if the last date of service not present • DTM01=150 if the last date of service is present
71 SERVICE DATES TO SER DT TO *[Detail level]*	Latest date of service or discharge date for the claim detail.	*Claim Adjustments*, *Claims Denied*, *Claims Paid*, and *Claims in Process*	DTM02, DTM01=151
72 SERVICE DATES FROM *[Header level]*	Earliest date of service or admission date for the claim.	*Claim Adjustments*, *Claims Denied*, *Claims Paid*, and *Claims in Process*	DTM02 using qualifier code 232

Field Name	Description	RA Section (and Claim Type)	835 Transaction Information
73 SERVICE DATES TO *[Header level]*	Last date of service or discharge for the claim.	*Claim Adjustments, Claims Denied, Claims Paid,* and *Claims in Process*	DTM02 using qualifier code 233
74 SERVICE DATES FROM	The earliest date of service or admission date for the claim related to the expenditure.	*Financial Transactions – Non-Claim Specific Payouts to Payee*	
75 SERVICE DATES THRU	The latest date of service or discharge for the claim related to the expenditure.	*Financial Transactions – Non-Claim Specific Payouts to Payee*	
76 SERVICE DT SERVICE DATE	Date the service was rendered (for the detail or for the claim header).	*Claim Adjustments, Claims Denied, Claims Paid,* and *Claims in Process* (Dental and Outpatient)	DTM02 • DTM01=472 if the last date of service not present • DTM01=150 if it is present
77 SETUP DATE	System-assigned date the account receivable was established in the system, manually or systematically.	*Financial Transactions – Accounts Receivable*	
78 SPENDDOWN SPENDDOWN AMT *[Detail level]*	Amount applied (from a particular service) toward the member's Medicaid waiver liability. For members with a Medicaid waiver liability, a qualifying county worker assigns a monthly liability amount based on the member's income and other factors. The member must spend this amount on medical expenses before Medicaid benefits become available.	*Claim Adjustments, Claims Denied, Claims Paid,* and *Claims in Process* (Medicare Crossover Institutional and Medicare Crossover Professional)	
79 SPENDDOWN SPENDDOWN AMOUNT SPENDDOWN AMT *[Header level]*	Amount applied (from the current RA) toward the member's Medicaid waiver liability. For members with a Medicaid waiver liability, a qualifying county worker assigns a monthly amount based on the member's income and other factors. The member must spend this amount on medical expenses before Medicaid benefits become available.	*Claim Adjustments, Claims Denied, Claims Paid,* and *Claims in Process*	

Field Name	Description	RA Section (and Claim Type)	835 Transaction Information
80 SURFACE	Code pertaining to the part of the tooth that was worked on.	*Claim Adjustments*, *Claims Denied*, *Claims Paid*, and *Claims in Process* (Dental)	
81 SVC CODE / DESCRIPTION	List of all procedure codes and revenue codes represented on the RA, along with corresponding descriptions.	*Service Code Descriptions*	
82 TOOTH	Tooth number, from the dental claim form diagram, of the tooth receiving treatment.	*Claim Adjustments*, *Claims Denied*, *Claims Paid*, and *Claims in Process* (Dental)	
83 TRANSACTION NUMBER	Number that uniquely identifies an expenditure transaction.	*Financial Transactions* and *Medical Education Cost Expenditures*	PLB03-2
84 TRANSACTION TYPE	Indicates the source of the payment. Examples of transaction types are *expenditure*, or a specific claim type.	*Payment Hold*	

Explanation of Benefits Codes

Each RA provides four-digit EOB codes. These codes and the corresponding narratives indicate that the submitted claim paid as billed or describe the reason the claim suspended, was denied, was adjusted, or did not pay in full. Because the claim can have edits and audits at the header and detail levels, EOB codes are listed for header and detail information. The header lists a maximum of 20 EOBs, and each detail line lists a maximum of 20 EOBs. Exceptions are suspended claims, which have a maximum of two EOBs per header and per detail. **EOBs for suspended claims are not denial codes, but list the reason the claim is being reviewed.**

EOB codes are listed immediately following the claim header and detail information, beside the label **EOBS** on the RA. EOB 000 lists header codes, EOB 001 lists line one of the claim's codes, and EOB 002 lists line two of the claim's codes. If there are no EOBs posted for a particular EOB XXX line, the line does not print.

Narrative descriptions of the EOB codes used on an RA appear in the *EOB Reason Code Descriptions* section of the RA. See the *Explanation of Benefits* page at in.gov/medicaid/providers for a complete list of all EOBs. Table 2 provides some examples of EOB codes and narratives, and indicates what action is required of the provider in each case.

EOBs are considered local codes and are not transmitted in the 835 transaction.

Table 2 – Explanation of Benefits Code Examples

Code	Description	Provider Action Required
0000	Claim paid as billed.	No action required.
0001	Claim pended for examiner review.	No action required. Follow the progress of the claim on the RA or use the Interactive Voice Response (IVR) system.
0201	Billing LPI/NPI is missing; please provide and resubmit.	Resubmit claim with NPI or IHCP Provider ID (formerly known as the Legacy Provider Identifier [LPI]).
0203	Member I.D. number is missing; please provide and resubmit.	Resubmit claim with the IHCP member identification number (known as Member ID or RID).
2014	Personal resources collected does not agree with amount reported by county office. Liability amount deducted from your claim was based on the amount reported by the county office.	Verify the personal resource amount with the county office. When verified and corrected, return the adjustment request form. When adjustment is complete, resubmit the claim.
4033	The modifier used is not compatible with the procedure code billed. Please verify and resubmit.	See Current Procedural Terminology (CPT®[1]) code manual and resubmit claim with correct modifier.
6650	The number of services provided exceeds medical policy guidelines. This is a once-in-lifetime procedure.	For billing policies and procedures, see the appropriate provider reference module for the service rendered (available on the *IHCP Provider Reference Modules* page at in.gov/medicaid/providers).

Adjustment Reason Codes

ARCs are provided with each claim or financial transaction in the weekly RA.

Claim-Specific ARCs

A complete list of claim-specific ARCs is available on the Washington Publishing Company website at wpc-edi.com. These ARCs and the corresponding narratives describe the adjustment reason reported from each claim that adjudicated as denied or not paid in the full amount as billed.

Claim-specific ARCs are alphanumeric codes from an external national code set used with the *835 Implementation Guide* to report the associated dollars from the adjustment between the billed amount and the allowed or paid amount. Because the claim can process against edits and audits at the claim (header) and service line (detail) levels, these ARCs can be reported for either service line and claim level or both. A maximum of 20 ARCs can be listed on the RA at the claim level, and a maximum of 20 ARCs can be listed for each service line. Exceptions are suspended claims, which have a maximum of two ARCs per claim level and per service-line level. **ARCs for suspended claims are not denial codes, but rather the reason the claim is being reviewed.**

Claim-specific ARCs are listed immediately following the EOBs, beside the label **ARCS** on the RA. ARC 000 lists claim-level reported codes. ARC 001 lists service line one of the claim's codes, and ARC 002 lists service line two of the claim's codes. If no ARCs are posted for a particular service-line detail, the line does not print. Narrative descriptions of the ARCs used on an RA appear in the *Adjustment Reason Code Descriptions* section of the RA. Table 3 lists examples of claim-specific ARCs and narratives.

[1] *CPT copyright 2019 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.*

Table 3 – Adjustment Reason Code Examples

EOB	ARC	ARC Description	Remark
0201	206	National Provider Identifier missing.	N257 – Missing/incomplete/ invalid billing provider/supplier primary identifier.
0203	16	Claim/service lacks information or has submission/ billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N382 – Missing/incomplete/ invalid patient identifier.
2014	142	Monthly Medicaid patient liability amount.	No remark code available to further clarify.
4033	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N519 – Invalid combination of HCPCS modifiers.
6650	149	Lifetime benefit maximum has been reached for this service/benefit category.	No remark code available to further clarify.

Financial ARCs

The *835 Implementation Guide* PLB segment provides a complete list of nonclaim financial transaction ARCs. The financial ARCs are two-character alphanumeric codes associated with nonclaim financial transactions and activities that increase or decrease the net payment amount associated with the weekly RA. The financial ARCs are not part of the claim-specific ARC code set.

Adjustment Remark Codes

Each claim in the weekly RA includes adjustment remark codes when needed to clarify the reason for the adjustment to payment reported with a claim-related ARC. The Washington Publishing Company website at wpc-edi.com contains a complete list of claim-specific adjustment remark codes. Remark codes are provided with the adjustment reason reported from each claim that adjudicated as denied or not paid in the full amount as billed.

Remark codes are alphanumeric codes from an external national code set used with the *835 Implementation Guide* to report the associated dollars from the adjustment between the billed and the allowed or paid amount. Because the claim can process against edits and audits at the claim (header) and service line (detail) levels, the remark codes can be listed for either service line and claim level or both. The claim level can list a maximum of 20 remarks, and each service line can list a maximum of 20 remarks. Exceptions are suspended claims, which have a maximum of two remarks per claim level and per service-line level. **Remark codes for suspended claims are not denial codes, but the reason the claim is being reviewed.**

Remark codes immediately follow the ARCs, beside the **REMARKS** label on the RA. REMARK 000 lists claim-level reported codes. REMARK 001 lists service line one of the claim's codes, and REMARK 002 lists service line two of the claim's codes. If no remarks are posted for a particular REMARK XXX line, the line does not print. Narrative descriptions of the remark codes used on an RA appear in the *Remark Code Descriptions* section of the RA.

> *Note: In the 835 transaction, the remark codes are aggregated at the claim and service-line level.*

Summary Page

The final page of the RA is the *Summary* page. This page provides a complete accounting of claim processing and payment activity for the current cycle and year-to-date. Table 4 lists each field and a description of the information contained in the field. Where applicable, the table also includes a description of how the information appears on the 835 transaction.

Each field and section name is preceded by a letter that corresponds to the location of that field or section in Figure 22, for easy cross-reference.

Table 4 – RA *Summary* Page Fields

Field	Description	835 Transaction Information
CLAIMS DATA *This section organizes the claims processed for this provider.* • CURRENT NUMBER and CURRENT AMOUNT reflect counts and dollars for the current cycle as reflected on this RA. • MONTH-TO-DATE NUMBER and MONTH-TO-DATE AMOUNT reflect counts and dollars processed during the current calendar month up to the date reflected on this RA. • YEAR-TO-DATE NUMBER and YEAR-TO-DATE AMOUNT reflect counts and dollars processed year-to-date for this provider, including the current cycle.		
A CLAIMS PAID	Number of paid claims processed. Total dollar amount paid for those claims.	
B CLAIM ADJUSTMENTS	Number of claims adjusted that resulted in increased payments. Additional dollar amount paid for the adjusted claims.	
C CLAIMS INTEREST	Amount of interest paid on clean electronic claims not processed within 21 days from receipt and clean paper claims not processed within 30 days from receipt.	• Claim level: AMT02 using a qualifier of **I** – This segment appears in the claim loop, and the amount applies to the specific claim. • Provider level: PLB segment using a qualifier of **L6** – The PLB segment contains the total number of claim interest days and total interest amount for all the claims that had interest for the provider.
D TOTAL CLAIMS PAYMENTS	Total of claims paid, claims adjustment, and claim interest dollars. This amount ties to the Claims Payment line listed under the Earnings Data section.	
E CLAIMS DENIED	Total number of claims denied for payment.	
F CLAIMS IN PROCESS	Total number of claims suspended for additional review.	

Field	Description	835 Transaction Information
EARNINGS DATA *This section displays total amounts paid to the provider and the total earnings reflected for the provider.* • CURRENT AMOUNT reflects activity from this RA. • MONTH-TO-DATE AMOUNT reflects dollars processed during the current calendar month up to the date reflected on this RA. • YEAR-TO-DATE AMOUNT reflects total activity for this calendar year, including the activity specific to this RA.		
PAYMENTS		
G CLAIMS PAYMENTS	Sum total of claims paid, claims adjusted, and claim interest dollars. This amount ties to the Total Claims Payment line listed under the Claims Data section.	
H MANAGED CARE ADMINISTRATIVE PAYMENT	Total amount paid for *Care Select* patients.* * The *Care Select* program ended July 31, 2015.	PLB A *Care Select* administrative fee payment is a provider-level adjustment. The PLB segment contains a system-generated administrative payment number and the amount.
I HOOSIER HEALTHWISE CAPITATION PAYMENT	*Applicable only for Hoosier Healthwise MCEs* Total capitation payment for members assigned to a Hoosier Healthwise MCE.	
J HEALTHY INDIANA PLAN POWER ACCOUNT	*Applicable only for Healthy Indiana Plan (HIP) MCEs* Total HIP Personal and Wellness Responsibility (POWER) Account payment for members assigned to a HIP MCE.	
K HEALTHY INDIANA PLAN CAPITATION PAYMENT	*Applicable only for HIP MCEs* Total HIP capitation payment for members assigned to a HIP MCE.	
L PAYOUTS	Total amount of non-claim-specific payments included in the RA checkwrite total.	
ACCOUNTS RECEIVABLE		
M CLAIM SPECIFIC	Amount deducted from the RA checkwrite for outstanding A/Rs tied to specific to claims. The two fields in this section are: • CURRENT CYCLE – Offsets related to adjustments reflected on the current RA. • OUTSTANDING FROM PREVIOUS CYCLES – Offsets related to adjustments that were processed in prior cycles and recouped in the current cycle.	
N NON CLAIM SPECIFIC	Amount deducted from the RA checkwrite for outstanding A/Rs that are not related to a given claim, not including offsets issued for financial adjustment reason code 8412 – *Partial payments.*	

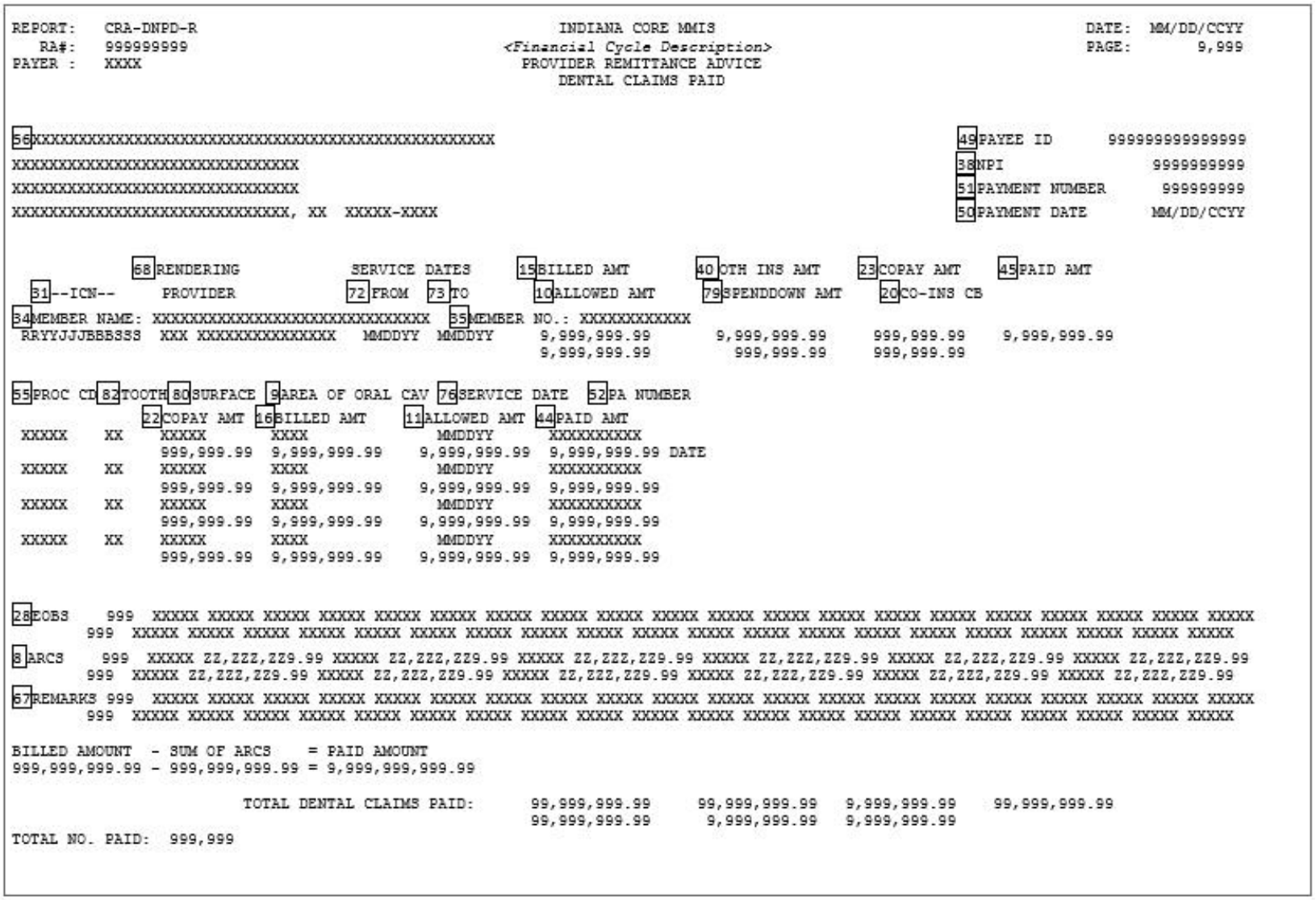
Field	Description	835 Transaction Information
O ADVANCEMENT RECOVERIES	Amount deducted from the RA checkwrite related to payment advances.	
REFUNDS		
P CLAIM SPECIFIC ADJUSTMENT REFUNDS	Amount received from the provider and applied to a given prior-paid claim.	PLB This adjustment refund is a check-related, claim-specific cash-receipt, provider-level adjustment. The PLB segment contains the daughter claim ICN/Claim ID and the amount. For these types of adjustments, the ICN/Claim ID of the daughter claim begins with 51.
Q NON CLAIM SPECIFIC REFUNDS	Amount the IHCP received in checks from the provider and applied against the provider's earnings, but not tied to a given prior-paid claim.	
OTHER FINANCIAL		
R MANUAL PAYOUTS	Amount reflects payments made to the provider outside *Core*MMIS, not included in any RA checkwrite total, but which must be included in total earnings.	
S VOIDS	Amount reflects IHCP payment checks returned to the Finance Unit uncashed.	PLB A void is a provider-level adjustment. The voided check number and amount appear as a positive or negative value on the PLB segment as required by the *835 Implementation Guide*. Void adjustments are not included in the provider payment amount; however, these adjustments are listed in the 835 transaction to inform the provider of the adjustment.
T MEMBER CONTRIBUTION (POWER)	Amount reflects the contributions the HIP member has paid toward his or her POWER Account.	
U NET PAYMENT	Amount equals the total amount of the check if a payment is due, or is zero if the amount of offset is equal to the amount of payment due. The total is determined by adding claim payments, managed care payments, and system payouts, and then subtracting claim-specific offsets, non-claim-specific offsets, and partial payment recoveries offsets (such as A/Rs).	BPR02
V NET EARNINGS	Net IHCP paid amount. This amount is calculated by adding the net payment and manual payouts, and then subtracting claim-specific refunds, non-claim-specific refunds, and voids. This total is the total reported to the IRS on the *1099*.	

Field	Description	835 Transaction Information
OUTSTANDING CHECKS		
W CHECK NUMBER	Number of the paper check that was issued.	
X ISSUE DATE	Date the checkwrite voucher is posted to the State accounting system. This is the Payment Date on the RA and paper checks.	
Y ISSUE AMOUNT	Amount of the payment issued.	
PAYMENTS TO LIEN HOLDERS *This section lists any payments made to lien holders that are deducted from the net payment made to the provider.*		
Z LIEN HOLDER NAME	Name of the entity receiving the lien amount withheld from the payee.	
ZZ LIEN AMOUNT	Amount withheld from the payee's check and paid to the lien holder.	PLB A lien is a provider-level adjustment. The PLB segment contains a system-generated lien number and the amount.

Remittance Advice Examples

The following pages display examples of IHCP RA statements. The examples include claim adjudication pages for different claim form types. The examples are representative of what a provider might see on an RA. These examples are *not* a comprehensive listing for each claim type.

Figure 4 – RA for Dental Claims Paid

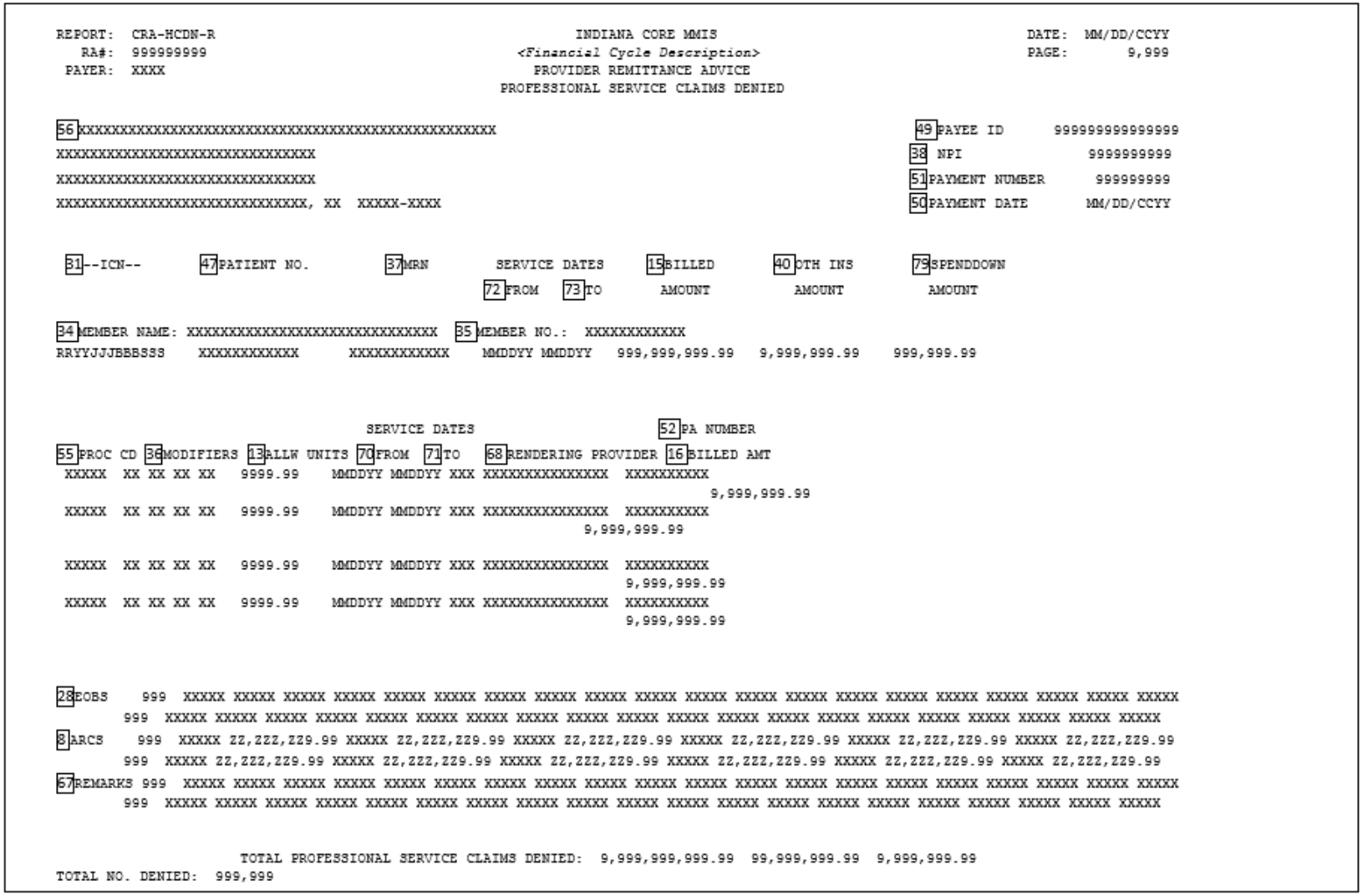


```
REPORT:   CRA-DNPD-R                          INDIANA CORE MMIS                          DATE:  MM/DD/CCYY
   RA#:   999999999                    <Financial Cycle Description>                    PAGE:       9,999
PAYER :   XXXX                           PROVIDER REMITTANCE ADVICE
                                             DENTAL CLAIMS PAID


56XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                    49PAYEE ID      999999999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                               38NPI                9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                               51PAYMENT NUMBER      999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, XX  XXXXX-XXXX                            50PAYMENT DATE       MM/DD/CCYY


            68RENDERING            SERVICE DATES     15BILLED AMT       40OTH INS AMT    23COPAY AMT    45PAID AMT
  31--ICN--      PROVIDER            72FROM  73TO       10ALLOWED AMT      79SPENDDOWN AMT    20CO-INS CB
34MEMBER NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  35MEMBER NO.: XXXXXXXXXXXX
 RRYYJJJBBBSSS  XXX XXXXXXXXXXXXXXX   MMDDYY  MMDDYY     9,999,999.99       9,999,999.99     999,999.99    9,999,999.99
                                                          9,999,999.99         999,999.99     999,999.99


55PROC CD 82TOOTH 80SURFACE  9AREA OF ORAL CAV 76SERVICE DATE  52PA NUMBER
            22COPAY AMT 16BILLED AMT    11ALLOWED AMT 44PAID AMT
 XXXXX    XX    XXXXX       XXXX             MMDDYY      XXXXXXXXXX
               999,999.99  9,999,999.99    9,999,999.99  9,999,999.99 DATE
 XXXXX    XX    XXXXX       XXXX             MMDDYY      XXXXXXXXXX
               999,999.99  9,999,999.99    9,999,999.99  9,999,999.99
 XXXXX    XX    XXXXX       XXXX             MMDDYY      XXXXXXXXXX
               999,999.99  9,999,999.99    9,999,999.99  9,999,999.99
 XXXXX    XX    XXXXX       XXXX             MMDDYY      XXXXXXXXXX
               999,999.99  9,999,999.99    9,999,999.99  9,999,999.99


28EOBS    999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX
       999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX

8ARCS     999  XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99
       999  XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99

67REMARKS 999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX
       999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX

BILLED AMOUNT  - SUM OF ARCS    = PAID AMOUNT
999,999,999.99 - 999,999,999.99 = 9,999,999,999.99

                        TOTAL DENTAL CLAIMS PAID:      99,999,999.99     99,999,999.99   9,999,999.99    99,999,999.99
                                                       99,999,999.99      9,999,999.99   9,999,999.99
TOTAL NO. PAID:  999,999
```

Figure 5 – RA for Professional Service Claims Paid

```
REPORT:   CRA-HCPD-R                              INDIANA CORE MMIS                                        DATE:  MM/DD/CCYY
   RA#:   999999999                          <Financial Cycle Description>                                 PAGE:       9,999
 PAYER:   XXXX                                PROVIDER REMITTANCE ADVICE
                                            PROFESSIONAL SERVICE CLAIMS PAID

[56]XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                      [49]PAYEE ID      999999999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                              [38] NPI                9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                              [51]PAYMENT NUMBER      999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, XX  XXXXX-XXXX                                               [50]PAYMENT DATE       MM/DD/CCYY

[31]--ICN--   [47]PATIENT NUMBER  [37]MRN        SERVICE DATES   [15]BILLED AMT    [40]OTH INS AMT  [23]COPAY AMT     [45]PAID AMT
                                              [72]FROM  [73]TO      [10]ALLOWED AMT  [79]SPENDDOWN AMT  [20]CO-INS CB    [32]OUTPAT DED
[34]MEMBER NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  [35]MEMBER NO.: XXXXXXXXXXXX
RRYYJJJBBBSSS  XXXXXXXXXXXX  XXXXXXXXXXXX   MMDDYY MMDDYY    9,999,999.99     9,999,999.99     999,999.99    9,999,999.99
                                                             9,999,999.99       999,999.99     999,999.99      999,999.99

                     SERVICE DATES [13]ALLW UNITS [68]RENDERING PROVIDER      [52]PA NUMBER
[55]PROC CD [36]MODIFIERS [70]FROM  [71]TO   [22]COPAY AMT[16]BILLED AMT [11]ALLOWED AMT[44]PAID AMT
 XXXXX  XX XX XX XX  MMDDYY MMDDYY 9999.99    XXX XXXXXXXXXXXXXXX       XXXXXXXXXX
                                   999,999.99 9,999,999.99 9,999,999.99 9,999,999.99
 XXXXX  XX XX XX XX  MMDDYY MMDDYY 9999.99    XXX XXXXXXXXXXXXXXX       XXXXXXXXXX
                                   999,999.99 9,999,999.99 9,999,999.99 9,999,999.99
 XXXXX  XX XX XX XX  MMDDYY MMDDYY 9999.99    XXX XXXXXXXXXXXXXXX       XXXXXXXXXX
                                   999,999.99 9,999,999.99 9,999,999.99 9,999,999.99
 XXXXX  XX XX XX XX  MMDDYY MMDDYY 9999.99    XXX XXXXXXXXXXXXXXX       XXXXXXXXXX
                                   999,999.99 9,999,999.99 9,999,999.99 9,999,999.99

[28]EOBS    999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX
        999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX
[8]ARCS     999  XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99
        999  XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99
[67]REMARKS 999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX
        999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX

BILLED AMOUNT  - SUM OF ARCS    = PAID AMOUNT
999,999,999.99 - 999,999,999.99 = 9,999,999,999.99

                    TOTAL PROFESSIONAL SERVICE CLAIMS PAID: 99,999,999.99    99,999,999.99   9,999,999.99    99,999,999.99
                                                            99,999,999.99     9,999,999.99   9,999,999.99     9,999,999.99
TOTAL NO. PAID: 999,999
```

Figure 6 – RA for Professional Service Claims Denied



```
REPORT:  CRA-HCDN-R                                  INDIANA CORE MMIS                                  DATE:  MM/DD/CCYY
   RA#:  999999999                          <Financial Cycle Description>                              PAGE:       9,999
 PAYER:  XXXX                                 PROVIDER REMITTANCE ADVICE
                                          PROFESSIONAL SERVICE CLAIMS DENIED

56 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                  49 PAYEE ID      999999999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                           38 NPI               9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                           51 PAYMENT NUMBER      999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, XX  XXXXX-XXXX                                         50 PAYMENT DATE       MM/DD/CCYY

 31 --ICN--        47 PATIENT NO.          37 MRN        SERVICE DATES      15 BILLED        40 OTH INS        79 SPENDDOWN
                                                       72 FROM  73 TO        AMOUNT           AMOUNT           AMOUNT

34 MEMBER NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  35 MEMBER NO.:  XXXXXXXXXXXX
RRYYJJJBBBSSS    XXXXXXXXXXXX      XXXXXXXXXXXX    MMDDYY MMDDYY   999,999,999.99   9,999,999.99    999,999.99


                                  SERVICE DATES                      52 PA NUMBER
55 PROC CD 36 MODIFIERS 13 ALLW UNITS 70 FROM  71 TO   68 RENDERING PROVIDER 16 BILLED AMT
 XXXXX  XX XX XX XX   9999.99    MMDDYY MMDDYY XXX XXXXXXXXXXXXXXX  XXXXXXXXXX
                                                                          9,999,999.99
 XXXXX  XX XX XX XX   9999.99    MMDDYY MMDDYY XXX XXXXXXXXXXXXXXX  XXXXXXXXXX
                                                                   9,999,999.99

 XXXXX  XX XX XX XX   9999.99    MMDDYY MMDDYY XXX XXXXXXXXXXXXXXX  XXXXXXXXXX
                                                                   9,999,999.99
 XXXXX  XX XX XX XX   9999.99    MMDDYY MMDDYY XXX XXXXXXXXXXXXXXX  XXXXXXXXXX
                                                                   9,999,999.99


28 EOBS    999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX
       999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX
8 ARCS     999  XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99
       999  XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99
67 REMARKS 999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX
       999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX


                    TOTAL PROFESSIONAL SERVICE CLAIMS DENIED:  9,999,999,999.99  99,999,999.99  9,999,999.99
TOTAL NO. DENIED:  999,999
```

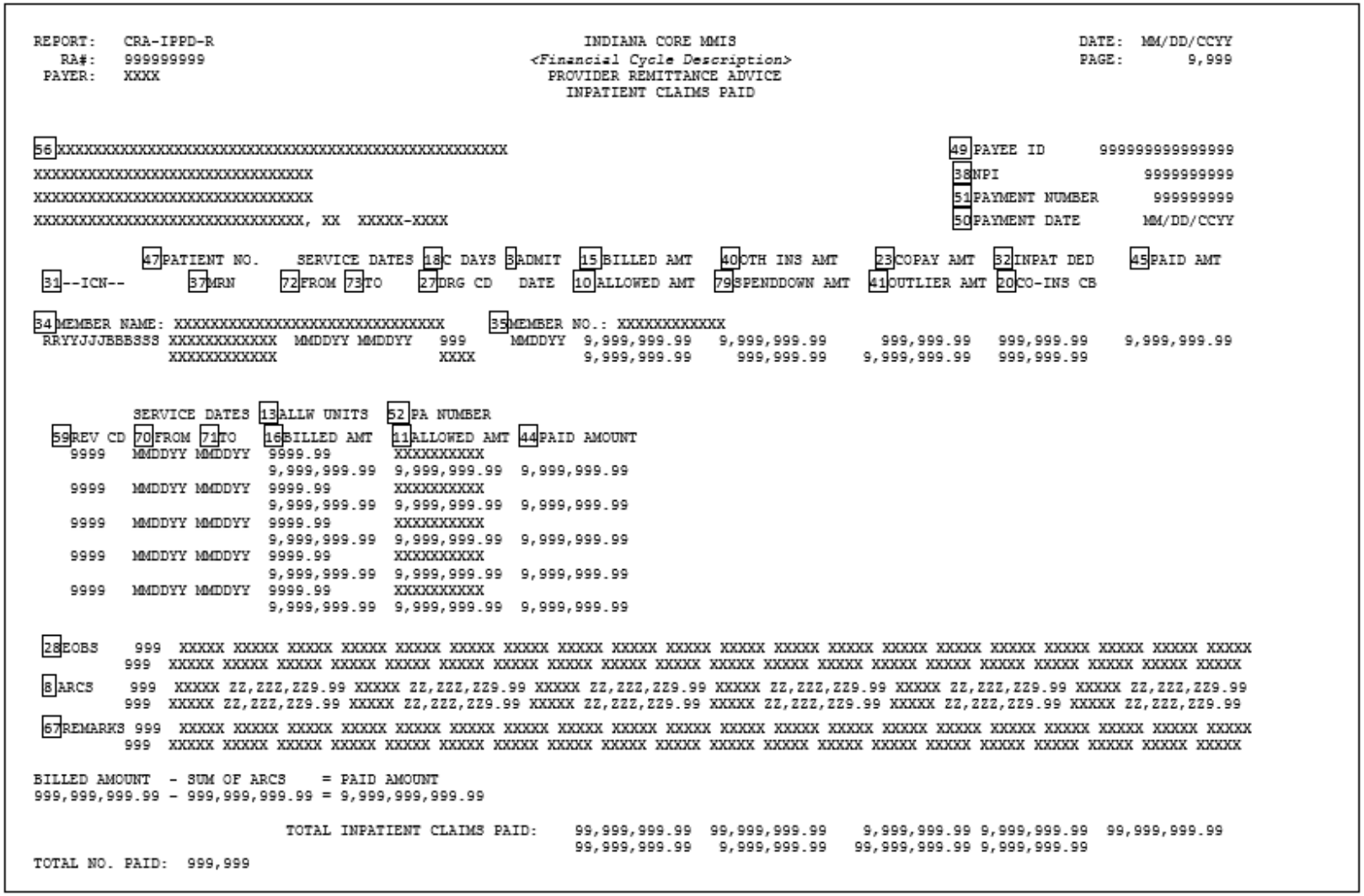
Figure 7 – RA for Professional Service Claims in Process

```
REPORT:   CRA-HCSU-R                          INDIANA CORE MMIS                          DATE:  MM/DD/CCYY
   RA#:   999999999                      <Financial Cycle Description>                  PAGE:       9,999
 PAYER:   XXXX                             PROVIDER REMITTANCE ADVICE
                                      PROFESSIONAL SERVICE CLAIMS IN PROCESS

56 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                    49 PAYEE ID      999999999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                             38 NPI               9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                             51 PAYMENT NUMBER      999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, XX  XXXXX-XXXX                             50 PAYMENT DATE       MM/DD/CCYY

31 --ICN--        47 PATIENT NO.       37 MRN        SERVICE DATES    15 BILLED          40 OTH INS
                                                   72 FROM  73 TO         AMOUNT             AMOUNT

34 MEMBER NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX          35 MEMBER NO.: XXXXXXXXXXXX
RRYYJJJBBBSSS   XXXXXXXXXXXX      XXXXXXXXXXXX   MMDDYY  MMDDYY    9,999,999.99     9,999,999.99


                      SERVICE DATES 13 ALLW   68 RENDERING          16 BILLED
55 PROC CD 86 MODIFIERS 70 FROM   71 TO  UNITS    PROVIDER             AMOUNT
 XXXXX   XX XX XX XX  MMDDYY MMDDYY  9999.99  XXX XXXXXXXXXXXXXXX  9,999,999.99
 XXXXX   XX XX XX XX  MMDDYY MMDDYY  9999.99  XXX XXXXXXXXXXXXXXX  9,999,999.99
 XXXXX   XX XX XX XX  MMDDYY MMDDYY  9999.99  XXX XXXXXXXXXXXXXXX  9,999,999.99
 XXXXX   XX XX XX XX  MMDDYY MMDDYY  9999.99  XXX XXXXXXXXXXXXXXX  9,999,999.99

28 EOBS    999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX
       999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX
8 ARCS     999  XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99
       999  XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99
87 REMARKS 999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX
       999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX


              TOTAL PROFESSIONAL SERVICE CLAIMS IN PROCESS:  99,999,999.99    99,999,999.99
TOTAL NO. IN PROCESS:  999,999
```

Figure 8 – RA for Professional Service Claim Adjustments

```
REPORT:   CRA-HCAD-R                                    INDIANA CORE MMIS                                DATE:  MM/DD/CCYY
   RA#:   999999999                               <Financial Cycle Description>                          PAGE:       9,999
 PAYER:   XXXX                                      PROVIDER REMITTANCE ADVICE
                                                PROFESSIONAL SERVICE CLAIM ADJUSTMENTS

[56]XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                 [49]PAYEE ID       999999999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                        [38]NPI                 9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                        [51]PAYMENT NUMBER       999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXX, XX  XXXXX-XXXX                                          [50]PAYMENT DATE        MM/DD/CCYY

[31]--ICN--      [47]PATIENT NO.     [37]MRN       SERVICE DATES   [15]BILLED AMT     [40]OTH INS AMT     [23]COPAY AMT      [45]PAID AMT
                                                  [72]FROM  [73]TO   [10]ALLOWED AMT   [79]SPENDDOWN AMT   [20]CO-INS CB     [32]OUTPAT DED

[34]MEMBER NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      [35]MEMBER NO.: XXXXXXXXXXXX
RRYYJJJBBBSSS  XXXXXXXXXXXX      XXXXXXXXXXXX   MMDDYY  MMDDYY   (9,999,999.99)    (9,999,999.99)   (999,999.99)   (9,999,999.99)
                                                                 (9,999,999.99)      (999,999.99)   (999,999.99)     (999,999.99)
RRYYJJJBBBSSS  XXXXXXXXXXXX      XXXXXXXXXXXX   MMDDYY M MDDYY    9,999,999.99      9,999,999.99     999,999.99    9,999,999.99
                                                                  9,999,999.99        999,999.99     999,999.99      999,999.99

                     SERVICE DATES[13]ALLW UNITS RENDERING PROVIDER      [52]PA NUMBER
[55]PROC CD [36]MODIFIERS  [70]FROM [71]TO   [22]COPAY AMT[16]BILLED AMT [11]ALLOWED AMT[44]PAID AMT
 XXXXX  XX XX XX XX  MMDDYY MMDDYY 9999.99    XXX XXXXXXXXXXXXXXX      XXXXXXXXXX
                                   999,999.99 9,999,999.99 9,999,999.99 9,999,999.99
 XXXXX  XX XX XX XX  MMDDYY MMDDYY 9999.99    XXX XXXXXXXXXXXXXXX      XXXXXXXXXX
                                   999,999.99 9,999,999.99 9,999,999.99 9,999,999.99
 XXXXX  XX XX XX XX  MMDDYY MMDDYY 9999.99    XXX XXXXXXXXXXXXXXX      XXXXXXXXXX
                                   999,999.99 9,999,999.99 9,999,999.99 9,999,999.99
 XXXXX  XX XX XX XX  MMDDYY MMDDYY 9999.99    XXX XXXXXXXXXXXXXXX      XXXXXXXXXX
                                   999,999.99 9,999,999.99 9,999,999.99 9,999,999.99

                                                                  [1]ADDITIONAL PAYMENT                        9,999,999.99
                                                                  [43]OVERPAYMENT TO BE WITHHELD               9,999,999.99
                                                                  [64]REFUND AMOUNT APPLIED                    9,999,999.99
ADJUSTMENT EOB:  9999

[28]EOBS    999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX
        999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX
[8]ARCS    999  XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99
        999  XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99
[67]REMARKS 999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX
        999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX

                     TOTAL PROFESSIONAL SERVICE CLAIMS ADJ:      99,999,999.99   99,999,999.99    9,999,999.99    99,999,999.99
                                                                 99,999,999.99    9,999,999.99    9,999,999.99     9,999,999.99
TOTAL NO. ADJ:  999,999
```

Figure 9 – RA for Inpatient Claims Paid



```
REPORT:   CRA-IPPD-R                          INDIANA CORE MMIS                          DATE:  MM/DD/CCYY
   RA#:   999999999                    <Financial Cycle Description>                    PAGE:       9,999
 PAYER:   XXXX                           PROVIDER REMITTANCE ADVICE
                                           INPATIENT CLAIMS PAID


[56]XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                    [49]PAYEE ID      999999999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                               [38]NPI               9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                               [51]PAYMENT NUMBER      999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, XX  XXXXX-XXXX                                [50]PAYMENT DATE       MM/DD/CCYY

          [47]PATIENT NO.    SERVICE DATES [18]C DAYS [3]ADMIT  [15]BILLED AMT   [40]OTH INS AMT    [23]COPAY AMT  [32]INPAT DED    [45]PAID AMT
 [31]--ICN--       [37]MRN     [72]FROM [73]TO    [27]DRG CD   DATE  [10]ALLOWED AMT  [79]SPENDDOWN AMT  [41]OUTLIER AMT [20]CO-INS CB

[34]MEMBER NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     [35]MEMBER NO.: XXXXXXXXXXXX
 RRYYJJJBBBSSS XXXXXXXXXXXX  MMDDYY MMDDYY   999      MMDDYY  9,999,999.99   9,999,999.99      999,999.99   999,999.99    9,999,999.99
               XXXXXXXXXXXX                  XXXX             9,999,999.99     999,999.99    9,999,999.99   999,999.99


          SERVICE DATES [13]ALLW UNITS  [52]PA NUMBER
  [59]REV CD [70]FROM [71]TO   [16]BILLED AMT  [11]ALLOWED AMT [44]PAID AMOUNT
    9999   MMDDYY MMDDYY  9999.99        XXXXXXXXXX
                          9,999,999.99  9,999,999.99  9,999,999.99
    9999   MMDDYY MMDDYY  9999.99        XXXXXXXXXX
                          9,999,999.99  9,999,999.99  9,999,999.99
    9999   MMDDYY MMDDYY  9999.99        XXXXXXXXXX
                          9,999,999.99  9,999,999.99  9,999,999.99
    9999   MMDDYY MMDDYY  9999.99        XXXXXXXXXX
                          9,999,999.99  9,999,999.99  9,999,999.99
    9999   MMDDYY MMDDYY  9999.99        XXXXXXXXXX
                          9,999,999.99  9,999,999.99  9,999,999.99

 [28]EOBS    999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX
           999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX

 [8]ARCS     999  XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99
           999  XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99

 [67]REMARKS 999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX
           999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX

BILLED AMOUNT  - SUM OF ARCS    = PAID AMOUNT
999,999,999.99 - 999,999,999.99 = 9,999,999,999.99

                          TOTAL INPATIENT CLAIMS PAID:    99,999,999.99  99,999,999.99    9,999,999.99 9,999,999.99  99,999,999.99
                                                          99,999,999.99   9,999,999.99   99,999,999.99 9,999,999.99
TOTAL NO. PAID:  999,999
```

Figure 10 – RA for Outpatient Claims Paid

```
REPORT:   CRA-OPPD-R                          INDIANA CORE MMIS                          DATE:  MM/DD/CCYY
  RA#:    999999999                      <Financial Cycle Description>                 PAGE:       9,999
 PAYER:   XXXX                             PROVIDER REMITTANCE ADVICE
                                             OUTPATIENT CLAIMS PAID

[56]XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                    [49]PAYEE ID      999999999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                 [38]NPI                9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                 [51]PAYMENT NUMBER      999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, XX  XXXXX-XXXX                              [50]PAYMENT DATE       MM/DD/CCYY

                                          SERVICE DATES   [15]BILLED AMT     [40]OTH INS AMT   [23]COPAY AMT     [45]PAID AMT
 [31]--ICN--    [47]PATIENT NO.      [37]MRN     [72]FROM [73]TO       [10]ALLOWED AMT   [79]SPENDDDOWN AMT  [20]CO-INS CB  [42]OUTPAT DED

[34]MEMBER NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      [35]MEMBER NO.: XXXXXXXXXXXX
RRYYJJJBBBSSS   XXXXXXXXXXXX   XXXXXXXXXXXX   MMDDYY MMDDYY     9,999,999.99     9,999,999.99     999,999.99     9,999,999.99
                                                                  9,999,999.99       999,999.99     999,999.99       999,999.99

              [36]MODIFIERS  [76]SERVICE DT  [13]ALLW UNITS  [52]PA NUMBER
 [69]REV CD [65]PROC CD [22]COPAY AMT[16]BILLED AMT  [11]ALLOWED AMT [44]PAID AMOUNT
    9999    XXXXX   XX XX XX XX  MMDDYY        9999.99        XXXXXXXXXX
                    999,999.99   9,999,999.99  9,999,999.99  9,999,999.99
    9999    XXXXX   XX XX XX XX  MMDDYY        9999.99        XXXXXXXXXX
                    999,999.99   9,999,999.99  9,999,999.99  9,999,999.99
    9999    XXXXX   XX XX XX XX  MMDDYY        9999.99        XXXXXXXXXX
                    999,999.99   9,999,999.99  9,999,999.99  9,999,999.99
    9999    XXXXX   XX XX XX XX  MMDDYY        9999.99        XXXXXXXXXX
                    999,999.99   9,999,999.99  9,999,999.99  9,999,999.99

[28]EOBS    999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX
       999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX
[8]ARCS     999  XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99
       999  XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99
[67]REMARKS 999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX
       999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX

BILLED AMOUNT  - SUM OF ARCS    = PAID AMOUNT
999,999,999.99 - 999,999,999.99 = 9,999,999,999.99

                         TOTAL OUTPATIENT CLAIMS PAID:      99,999,999.99     99,999,999.99  9,999,999.99    99,999,999.99
                                                            99,999,999.99      9,999,999.99  9,999,999.99     9,999,999.99
TOTAL NO. PAID:  999,999
```

Figure 11 – RA for Home Health Claims Paid

```
REPORT:   CRA-HHPD-R                              INDIANA CORE MMIS                                  DATE:  MM/DD/CCYY
   RA#:   999999999                          <Financial Cycle Description>                          PAGE:       9,999
 PAYER:   XXXX                                 PROVIDER REMITTANCE ADVICE
                                                HOME HEALTH CLAIMS PAID

56 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                          49 PAYEE ID      999999999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                     38 NPI                9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                     51 PAYMENT NUMBER      999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, XX  XXXXX-XXXX                                  50 PAYMENT DATE       MM/DD/CCYY

                                        SERVICE DATES 15 BILLED       10 ALLOWED      40 OTH INS      48 PATIENT    45 PAID
31 --ICN--    47 PATIENT NO.    37 MRN     72 FROM  73 TO    AMOUNT         AMOUNT          AMOUNT          LIAB         AMOUNT

54 MEMBER NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  35 MEMBER NO.: XXXXXXXXXXXX
RRYYJJJBBBSSS XXXXXXXXXXXX XXXXXXXXXXXX MMDDYY MMDDYY 9,999,999.99   9,999,999.99   9,999,999.99   999,999.99   9,999,999.99

                                SERVICE DATES  13 ALLW UNITS  52 PA NUMBER
69 REV CD 55 PROC CD  36 MODIFIERS 70 FROM 71 TO  16 BILLED AMT  11 ALLOWED AMT  44 PAID AMOUNT
 9999    XXXXX    XX XX XX XX  MMDDYY MMDDYY  9999.99        XXXXXXXXXX
                                              9,999,999.99  9,999,999.99  9,999,999.99

 9999    XXXXX    XX XX XX XX  MMDDYY MMDDYY  9999.99        XXXXXXXXXX
                                              9,999,999.99  9,999,999.99  9,999,999.99

 9999    XXXXX    XX XX XX XX  MMDDYY MMDDYY  9999.99        XXXXXXXXXX
                                              9,999,999.99  9,999,999.99  9,999,999.99

28 EOBS    999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX
       999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX
8 ARCS     999  XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99
       999  XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99
67 REMARKS 999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX
       999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX

BILLED AMOUNT  - SUM OF ARCS    = PAID AMOUNT
999,999,999.99 - 999,999,999.99 = 9,999,999,999.99

                              TOTAL HOME HEALTH CLAIMS PAID: 99,999,999.99  99,999,999.99  99,999,999.99  9,999,999.99  99,999,999.99
TOTAL NO. PAID:  999,999
```

Figure 12 – RA for Long Term Care Claims Paid

```
REPORT:   CRA-LTPD-R                          INDIANA CORE MMIS                          DATE:  MM/DD/CCYY
   RA#:   999999999                  <Financial Cycle Description>                     PAGE:       9,999
 PAYER:   XXXX                         PROVIDER REMITTANCE ADVICE
                                       LONG TERM CARE CLAIMS PAID

56 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                    49 PAYEE ID      999999999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                               38 NPI                9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                               51 PAYMENT NUMBER      999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, XX  XXXXX-XXXX                               50 PAYMENT DATE       MM/DD/CCYY

                                    SERVICE DATES 25 DAYS 21 COND 15 BILLED     10 ALLOWED     40 OTH INS     48 PATIENT     45 PAID
31 --ICN--    47 PATIENT NO.   37 MRN     72 FROM 73 TO          CODE   AMOUNT       AMOUNT         AMOUNT         LIAB         AMOUNT

34 MEMBER NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  35 MEMBER NO.: XXXXXXXXXXXX
RRYYJJJBBBSSS XXXXXXXXXXXX XXXXXXXXXXXX MMDDYY MMDDYY 999   XX  9,999,999.99   9,999,999.99   9,999,999.99   999,999.99   9,999,999.99

                  SERVICE DATES 13 ALLW UNITS  52 PA NUMBER
69 REV CD 65 PROC CD 70 FROM 71 TO    16 BILLED AMT   11 ALLOWED AMT 44 PAID AMOUNT
 9999     XXXXX     MMDDYY MMDDYY   9999.99          XXXXXXXXXX
                                    9,999,999.99    9,999,999.99   9,999,999.99
 9999     XXXXX     MMDDYY MMDDYY   9999.99          XXXXXXXXXX
                                    9,999,999.99    9,999,999.99   9,999,999.99
 9999     XXXXX     MMDDYY MMDDYY   9999.99          XXXXXXXXXX
                                    9,999,999.99    9,999,999.99   9,999,999.99


28 EOBS    999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX
       999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX
8 ARCS     999  XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99
       999  XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99
67 REMARKS 999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX
       999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX

BILLED AMOUNT  - SUM OF ARCS    = PAID AMOUNT
999,999,999.99 - 999,999,999.99 = 9,999,999,999.99

                          TOTAL LONG TERM CARE CLAIMS PAID: 99,999,999.99  99,999,999.99  99,999,999.99  9,999,999.99  99,999,999.99
TOTAL NO. PAID:  999,999
```

Figure 13 – RA for Medicare Crossover Professional Service Claims Paid

```
REPORT:   CRA-XBPD-R                                    INDIANA CORE MMIS                                          DATE:  MM/DD/CCYY
   RA#:   999999999                               <Financial Cycle Description>                                    PAGE:       9,999
 PAYER:   XXXX                                     PROVIDER REMITTANCE ADVICE
                                       MEDICARE CROSSOVER PROFESSIONAL SERVICE CLAIMS PAID


56XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                49PAYEE ID      999999999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                     38NPI                 9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                     51PAYMENT NUMBER       999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXX, XX  XXXXX-XXXX                                                      50PAYMENT DATE       MM/DD/CCYY


                                              |-M  E  D  I  C  A  R  E   A M T S-|
  31--ICN--    47PATIENT NO.   SERVICE DATES   24COPAY AMT 12ALLOWED AMT 57PSYCH CO-INS  15BILLED    23COPAY AMT 32OUTPAT DED 45PAID AMT
                   37MRN       72 FROM 73 TO      46 PAID AMT   26DEDUCT     19CO-INS   40OTH INS AMT 79SPENDDOWN    20CO-INS CB

34MEMBER NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      35MEMBER NO.: XXXXXXXXXXXX
 RRYYJJJBBBSSS  XXXXXXXXXXXX  MMDDYY MMDDYY    999,999.99  9,999,999.99  999,999.99   9,999,999.99  999,999.99  999,999.99  9,999,999.99
                XXXXXXXXXXXX                 9,999,999.99    999,999.99  999,999.99   9,999,999.99  999,999.99  999,999.99


              36MODIFIERS   SER DT70FROM71TO68RENDERING PROV    13ALLW UNITS 52PA NUMBER
69REV CD 55PROC CD 22COPAY AMT  78SPENDDOWN AMT 16BILLED AMT  11ALLOWED AMT  44PAID AMT
 9999   XXXXX   XX XX XX XX  MMDDYY MMDDYY   XXX XXXXXXXXXXXXXXX 9999.99  XXXXXXXXXX
                999,999.99   999,999.99      9,999,999.99  9,999,999.99 9,999,999.99
 9999   XXXXX   XX XX XX XX  MMDDYY MMDDYY   XXX XXXXXXXXXXXXXXX 9999.99  XXXXXXXXXX
                999,999.99   999,999.99      9,999,999.99  9,999,999.99 9,999,999.99
 9999   XXXXX   XX XX XX XX  MMDDYY MMDDYY   XXX XXXXXXXXXXXXXXX 9999.99  XXXXXXXXXX
                999,999.99   999,999.99      9,999,999.99  9,999,999.99 9,999,999.99
 9999   XXXXX   XX XX XX XX  MMDDYY MMDDYY   XXX XXXXXXXXXXXXXXX 9999.99  XXXXXXXXXX
                999,999.99   999,999.99      9,999,999.99  9,999,999.99 9,999,999.99
 9999   XXXXX   XX XX XX XX  MMDDYY MMDDYY   XXX XXXXXXXXXXXXXXX 9999.99  XXXXXXXXXX
                999,999.99   999,999.99      9,999,999.99  9,999,999.99 9,999,999.99

28EOBS     999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX
        999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX
8ARCS     999  XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99
        999  XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99
67REMARKS 999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX
        999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX

BILLED AMOUNT  - SUM OF ARCS    = PAID AMOUNT
999,999,999.99 - 999,999,999.99 = 9,999,999,999.99

TOTAL MEDICARE CROSSOVER PROFESSIONAL SERVICE CLAIMS PAID:
                                                9,999,999.99 99,999,999.99  9,999,999.99    9,999,999.99  9,999,999.99 99,999,999.99
                                               99,999,999.99  9,999,999.99  9,999,999.99   99,999,999.99 99,999,999.99
TOTAL NO. PAID:  999,999
```

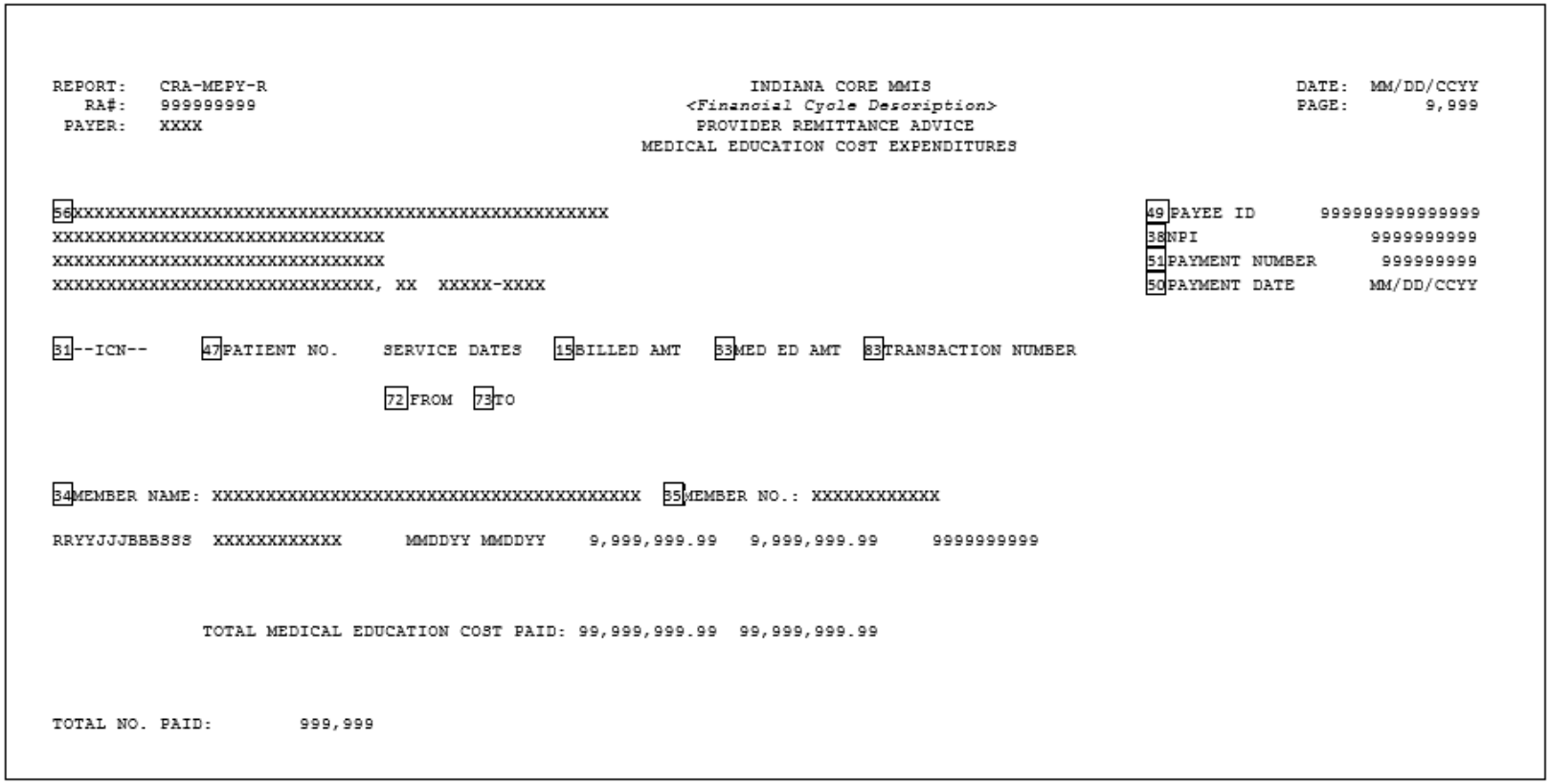
Figure 14 – RA for Medicare Crossover Institutional Claims Paid

```
REPORT:   CRA-XAPD-R                          INDIANA CORE MMIS                          DATE:  MM/DD/CCYY
   RA#:   999999999                    <Financial Cycle Descriptions>                   PAGE:       9,999
 PAYER:   XXXX                           PROVIDER REMITTANCE ADVICE
                                  MEDICARE CROSSOVER INSTITUTIONAL CLAIMS PAID


[56]XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                    [49]PAYEE ID      999999999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                 [38]NPI               9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                 [51]PAYMENT NUMBER      999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, XX  XXXXX-XXXX                               [50]PAYMENT DATE       MM/DD/CCYY

                          SERVICE DATES    |-M  E  D  I  C  A  R  E   A M T S-|

 [31]--ICN--  [47]PATIENT NO.[72]FROM [73]TO     [24]COPAY AMT  [17]BLOOD DEDUCT  [19]CO-INS [15]BILLED AMT [23]COPAY AMT[32]INPAT/OUTPAT DED[48]PATIENT LIAB

              [37]MRN    [3]ADMIT DT [25]DAYS   [46]PAID AMT     [26]DEDUCT          [40]OTH INS AMT [79]SPENDDOWN [20]CO-INS CB     [45]PAID AMT

 [34]MEMBER NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  [35]MEMBER NO.: XXXXXXXXXXXX
RRYYJJJBBBSS  XXXXXXXXXXXX MMDDYY MMDDYY    999,999.99   999,999.99   999,999.99  9,999,999.99  999,999.99  999,999.99    999,999.99
              XXXXXXXXXXXX MMDDYY   999   9,999,999.99   999,999.99               9,999,999.99  999,999.99  999,999.99  9,999,999.99

[69]REV CD [55]PROC CD [36]MODIFIERS  SER DT [70]FROM[71]TO [68]RENDERING PROV  [13]ALLW UNITS [52]PA NUMBER

            [22]COPAY AMT  [78]SPENDDOWN AMT [16]BILLED AMT  [11]ALLOWED AMT    [44]PAID AMT

9999   XXXXX   XX XX XX XX  MMDDYY MMDDYY   XXX XXXXXXXXXXXXXXX 9999.99  XXXXXXXXXX

               999,999.99   999,999.99      9,999,999.99  9,999,999.99 9,999,999.99

[28]EOBS    999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX
       999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX
[8]ARCS     999  XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99
       999  XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99 XXXXX ZZ,ZZZ,ZZ9.99
[67]REMARKS 999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX
       999  XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX

BILLED AMOUNT  - SUM OF ARCS    = PAID AMOUNT
999,999,999.99 - 999,999,999.99 = 9,999,999,999.99

TOTAL MEDICARE CROSSOVER INSTITUTIONAL CLAIMS PAID:
                                    9,999,999.99  9,999,999.99 9,999,999.99 99,999,999.99 999,999.99 9,999,999.99  9,999,999.99
                                    9,999,999.99  9,999,999.99              99,999,999.99 999,999.99 9,999,999.99 99,999,999.99

TOTAL NO. PAID:  999,999
```

Figure 15 – RA Payment Hold

```
REPORT:   CRA-PEND-R                                  INDIANA CORE MMIS                                  DATE:  MM/DD/CCYY
   RA#:   999999999                                <Financial Cycle Description>                          PAGE:       9,999
 PAYER:   XXXX                                      PROVIDER REMITTANCE ADVICE
                                                          PAYMENT HOLD

56XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                  49PAYEE ID      999999999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                         38NPI                9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                         51PAYMENT NUMBER      999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, XX  XXXXX-XXXX                                      50PAYMENT DATE       MM/DD/CCYY


  THE FOLLOWING TRANSACTIONS WERE HELD DUE TO:

  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

  REFERENCE NUMBER: 999999999


  84TRANSACTION TYPE        31ICN        4AMOUNT HELD

  XXXXXXXXXXXXXXXXXX   XXXXXXXXXXXXX   99,999,999.99
  XXXXXXXXXXXXXXXXXX   XXXXXXXXXXXXX   99,999,999.99
  XXXXXXXXXXXXXXXXXX   XXXXXXXXXXXXX   99,999,999.99
  XXXXXXXXXXXXXXXXXX   XXXXXXXXXXXXX   99,999,999.99
  XXXXXXXXXXXXXXXXXX   XXXXXXXXXXXXX   99,999,999.99

                TOTAL AMOUNT HELD:   999,999,999.99


  THE FOLLOWING TRANSACTIONS WERE HELD DUE TO:

  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

  REFERENCE NUMBER: 999999999


  84TRANSACTION TYPE        31ICN        4AMOUNT HELD

  XXXXXXXXXXXXXXXXXX   XXXXXXXXXXXXX   99,999,999.99
  XXXXXXXXXXXXXXXXXX   XXXXXXXXXXXXX   99,999,999.99
  XXXXXXXXXXXXXXXXXX   XXXXXXXXXXXXX   99,999,999.99
  XXXXXXXXXXXXXXXXXX   XXXXXXXXXXXXX   99,999,999.99
  XXXXXXXXXXXXXXXXXX   XXXXXXXXXXXXX   99,999,999.99

                TOTAL AMOUNT HELD:   999,999,999.99

           GRAND TOTAL AMOUNT HELD: 9,999,999,999.99
```

Figure 16 – RA Medical Education Cost Expenditure



```
REPORT:   CRA-MEPY-R                          INDIANA CORE MMIS                          DATE:  MM/DD/CCYY
   RA#:   999999999                    <Financial Cycle Description>                    PAGE:       9,999
 PAYER:   XXXX                           PROVIDER REMITTANCE ADVICE
                                    MEDICAL EDUCATION COST EXPENDITURES

56XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                  49PAYEE ID      999999999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                           38NPI                9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                           51PAYMENT NUMBER      999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, XX  XXXXX-XXXX                        50PAYMENT DATE       MM/DD/CCYY

31--ICN--      47PATIENT NO.    SERVICE DATES   15BILLED AMT   33MED ED AMT   83TRANSACTION NUMBER
                                72FROM  73TO

34MEMBER NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  35MEMBER NO.: XXXXXXXXXXXX

RRYYJJJBBBSSS  XXXXXXXXXXXX      MMDDYY MMDDYY    9,999,999.99   9,999,999.99     9999999999


              TOTAL MEDICAL EDUCATION COST PAID: 99,999,999.99  99,999,999.99


TOTAL NO. PAID:        999,999
```

Figure 17 – RA Financial Transactions

```
REPORT:   CRA-TRAN-R                                  INDIANA CORE MMIS                                 DATE:  MM/DD/CCYY
   RA#:   999999999                              <Financial Cycle Description>                          PAGE:       9,999
PAYER :   XXXX                                     PROVIDER REMITTANCE ADVICE
                                                     FINANCIAL TRANSACTIONS


56 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                               49 PAYEE ID      999999999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                      38 NPI                9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                      51 PAYMENT NUMBER      999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, XX  XXXXX-XXXX                                       50 PAYMENT DATE       MM/DD/CCYY


                              ---------------NON-CLAIM SPECIFIC PAYOUTS TO PAYEE---------------

  83 TRANSACTION    53 PAYOUT     59 REASON  30 FIN  SERVICE   DATE     65 RELATED
      NUMBER          AMOUNT        CODE      ARC  74 FROM   75 THRU    PROVIDER ID
    99999999999   9,999,999.99     9999     XXXXX MMDDYY    MMDDYY  999999999999999
    99999999999   9,999,999.99     9999     XXXXX MMDDYY    MMDDYY  999999999999999
    99999999999   9,999,999.99     9999     XXXXX MMDDYY    MMDDYY  999999999999999
    99999999999   9,999,999.99     9999     XXXXX MMDDYY    MMDDYY  999999999999999
    99999999999   9,999,999.99     9999     XXXXX MMDDYY    MMDDYY  999999999999999
    99999999999   9,999,999.99     9999     XXXXX MMDDYY    MMDDYY  999999999999999

  TOTAL PAYOUTS: 99,999,999.99


                              --------------NON-CLAIM SPECIFIC REFUNDS FROM PAYEE--------------

  83 TRANSACTION    63 REFUND     60 REASON   30 FIN       51 PAYMENT  61 RECEIPT  54 MEMBER NAME       35 MEMBER NO.
      NUMBER          AMOUNT        CODE       ARC           NUMBER      DATE
    99999999999   9,999,999.99     9999      XXXXX        999999999  MMDDYY    XXXXXXXXXXXX X X    XXXXXXXXXXXX
    99999999999   9,999,999.99     9999      XXXXX        999999999  MMDDYY    XXXXXXXXXXXX X X    XXXXXXXXXXXX
    99999999999   9,999,999.99     9999      XXXXX        999999999  MMDDYY    XXXXXXXXXXXX X X    XXXXXXXXXXXX
    99999999999   9,999,999.99     9999      XXXXX        999999999  MMDDYY    XXXXXXXXXXXX X X    XXXXXXXXXXXX
    99999999999   9,999,999.99     9999      XXXXX        999999999  MMDDYY    XXXXXXXXXXXX X X    XXXXXXXXXXXX
    99999999999   9,999,999.99     9999      XXXXX        999999999  MMDDYY    XXXXXXXXXXXX X X    XXXXXXXXXXXX
    99999999999   9,999,999.99     9999      XXXXX        999999999  MMDDYY    XXXXXXXXXXXX X X    XXXXXXXXXXXX
    99999999999   9,999,999.99     9999      XXXXX        999999999  MMDDYY    XXXXXXXXXXXX X X    XXXXXXXXXXXX

  TOTAL REFUNDS: 99,999,999.99

                              -----------------------ACCOUNTS RECEIVABLE-----------------------

              77 SETUP 39 ORIGINAL  62 RECOUPMENT                 58 REASON 30 FIN 54 MEMBER NAME      35 MEMBER NO. 2 ADJUSTMENT  54 PREVIOUS  5 AMOUNT RECOUPED
6 A/R NUMBER     DATE     AMOUNT    AMOUNT TO DATE  14 BALANCE      CODE  ARC                                        --ICN--        --ICN--      IN CURRENT CYCLE
XXXXXXXXXXXXX  MMDDYY 9,999,999.99  9,999,999.99  9,999,999.99  9999 XXXXX XXXXXXXXXXXX X X XXXXXXXXXXXX RRYYJJJBBBSSS RRYYJJJBBBSSS  9,999,999.99
XXXXXXXXXXXXX  MMDDYY 9,999,999.99  9,999,999.99  9,999,999.99  9999 XXXXX XXXXXXXXXXXX X X XXXXXXXXXXXX RRYYJJJBBBSSS RRYYJJJBBBSSS  9,999,999.99
XXXXXXXXXXXXX  MMDDYY 9,999,999.99  9,999,999.99  9,999,999.99  9999 XXXXX XXXXXXXXXXXX X X XXXXXXXXXXXX RRYYJJJBBBSSS RRYYJJJBBBSSS  9,999,999.99
XXXXXXXXXXXXX  MMDDYY 9,999,999.99  9,999,999.99  9,999,999.99  9999 XXXXX XXXXXXXXXXXX X X XXXXXXXXXXXX RRYYJJJBBBSSS RRYYJJJBBBSSS  9,999,999.99
XXXXXXXXXXXXX  MMDDYY 9,999,999.99  9,999,999.99  9,999,999.99  9999 XXXXX XXXXXXXXXXXX X X XXXXXXXXXXXX RRYYJJJBBBSSS RRYYJJJBBBSSS  9,999,999.99
XXXXXXXXXXXXX  MMDDYY 9,999,999.99  9,999,999.99  9,999,999.99  9999 XXXXX XXXXXXXXXXXX X X XXXXXXXXXXXX RRYYJJJBBBSSS RRYYJJJBBBSSS  9,999,999.99
XXXXXXXXXXXXX  MMDDYY 9,999,999.99  9,999,999.99  9,999,999.99  9999 XXXXX XXXXXXXXXXXX X X XXXXXXXXXXXX RRYYJJJBBBSSS RRYYJJJBBBSSS  9,999,999.99

               TOTAL RECOUPMENT    99,999,999.99                                                                                  99,999,999.99
```

Figure 18 – RA EOB Code Descriptions

```
REPORT:   CRA-EOBM-R                              INDIANA CORE MMIS                                    DATE:  MM/DD/CCYY
   RA#:   999999999                        <Financial Cycle Description>                               PAGE:       9,999
 PAYER:   XXXX                              PROVIDER REMITTANCE ADVICE
                                               EOB CODE DESCRIPTIONS

[56]XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                  [49]PAYEE ID      999999999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                          [38]NPI                9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                          [51]PAYMENT NUMBER      999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, XX  XXXXX-XXXX                                          [50]PAYMENT DATE       MM/DD/CCYY

[29]EOB CODE      [29]DESCRIPTION

  9999        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  9999        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  9999        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  9999        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
```

Figure 19 – RA Adjustment Reason Code Descriptions

```
REPORT:   CRA-ARCM-R                          INDIANA CORE MMIS                                    DATE:  MM/DD/CCYY
   RA#:   999999999                     <Financial Cycle Description>                               PAGE:       9,999
 PAYER:   XXXX                           PROVIDER REMITTANCE ADVICE
                                        ADJ REASON CODE DESCRIPTIONS

56 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                         49 PAYEE ID        999999999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                               38 NPI                  9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                               51 PAYMENT NUMBER        999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, XX  XXXXX-XXXX                                50 PAYMENT DATE         MM/DD/CCYY

7 ARC CODE     7 DESCRIPTION

99999        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
99999        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
99999        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
99999        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
```

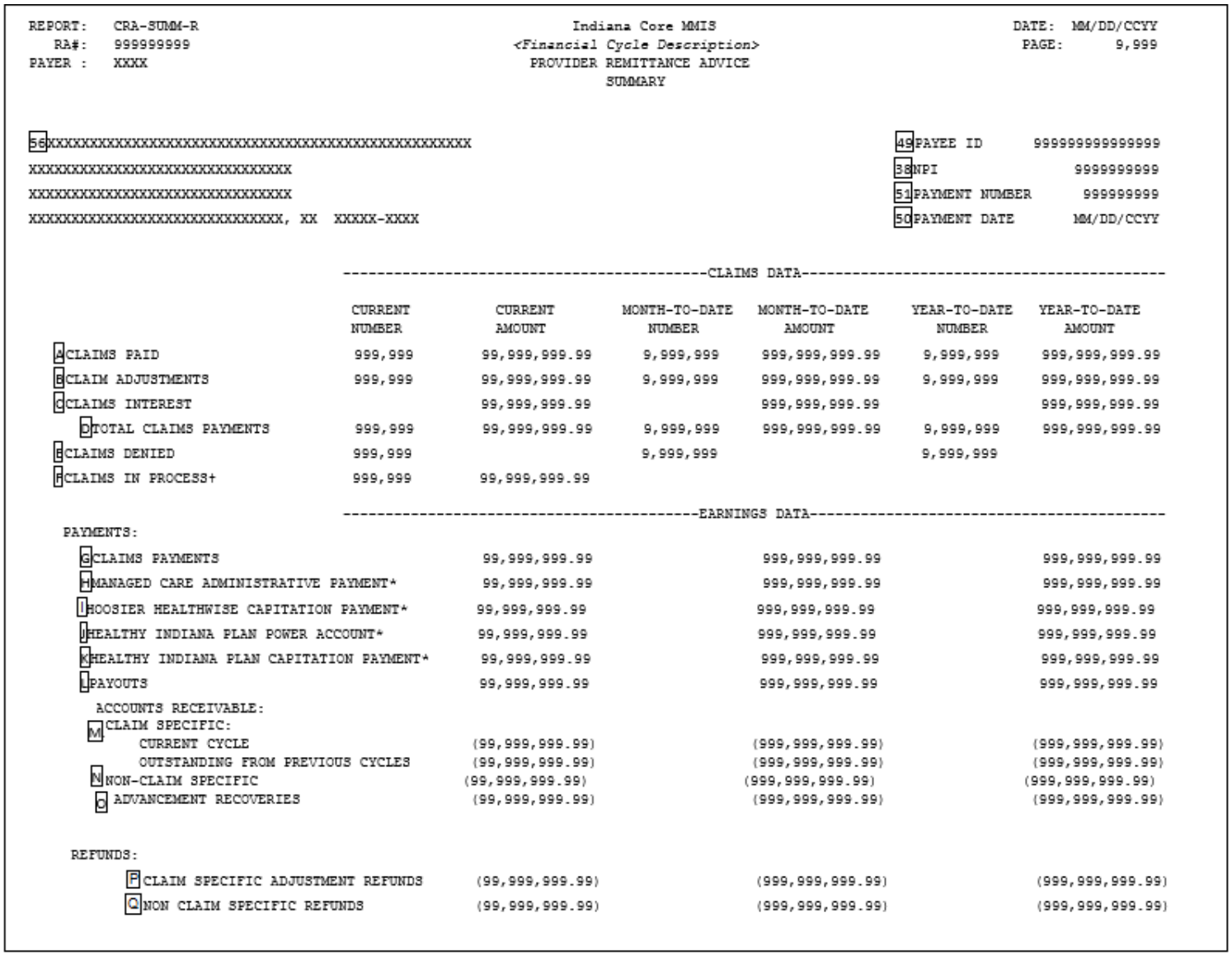
Figure 20 – RA Service Code Descriptions

```
REPORT:   CRA-DESC-R                              INDIANA CORE MMIS                                          DATE:  MM/DD/CCYY
   RA#:   999999999                        <Financial Cycle Description>                                     PAGE:       9,999
 PAYER:   XXXX                              PROVIDER REMITTANCE ADVICE
                                            SERVICE CODE DESCRIPTIONS

[56]XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                              [49]PAYEE ID      999999999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                     [38]NPI                 9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                     [51]PAYMENT NUMBER       999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, XX  XXXXX-XXXX                                      [50]PAYMENT DATE        MM/DD/CCYY

 [81]SVC CODE  [81]DESCRIPTION

  XXXXX        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
               XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
               XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
               XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
               XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  XXXXX        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
               XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
               XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
               XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
               XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  XXXXX        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
               XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
               XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
               XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
               XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  XXXXX        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
               XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
               XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
               XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
               XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
```

Figure 21 – RA Remark Code Descriptions

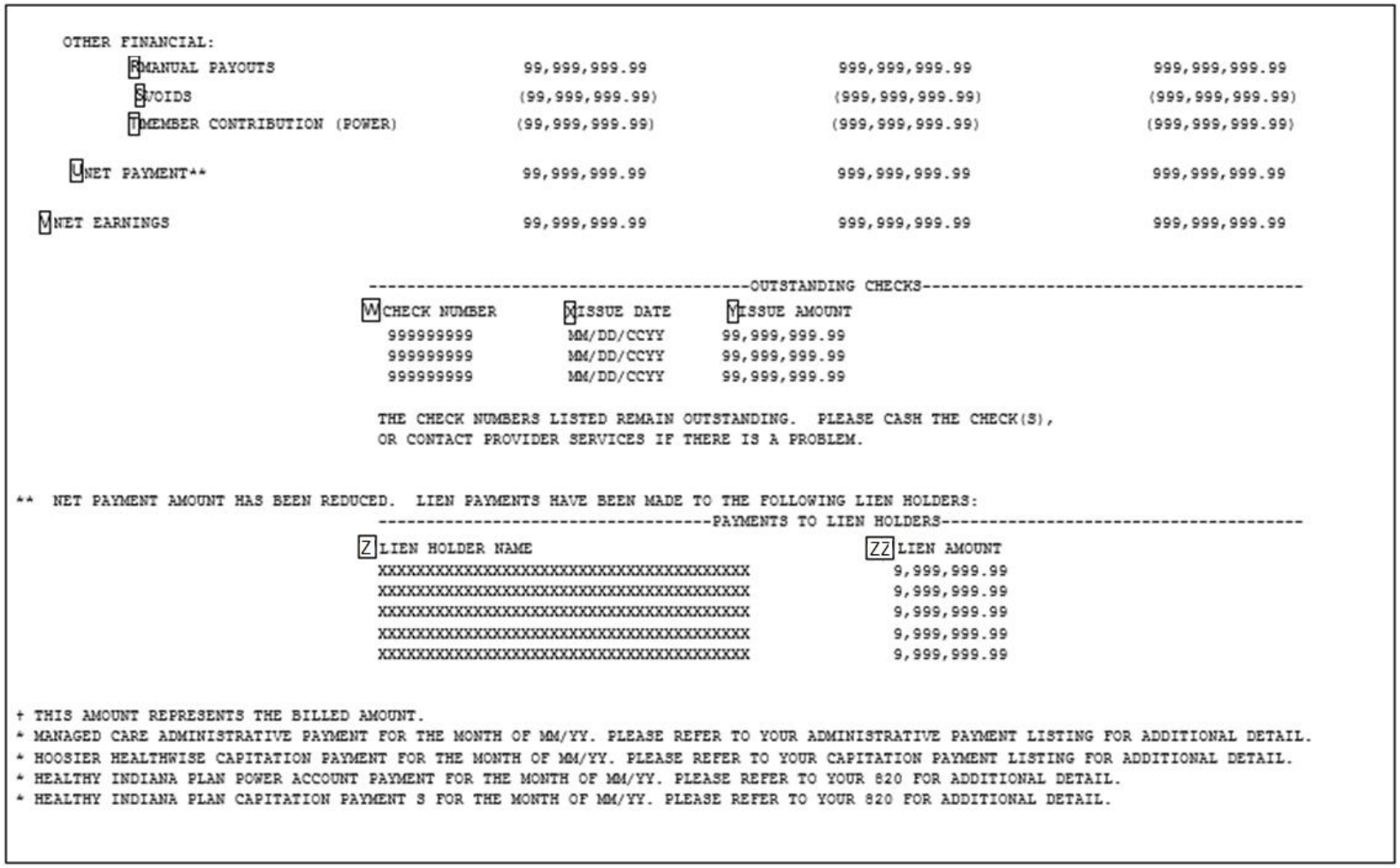
```
REPORT:   CRA-REMM-R                              INDIANA CORE MMIS                                          DATE:  MM/DD/CCYY
   RA#:   999999999                          <Financial Cycle Description>                                   PAGE:       9,999
 PAYER:   XXXX                                PROVIDER REMITTANCE ADVICE
                                              REMARK CODE DESCRIPTIONS

56XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                     49PAYEE ID      999999999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                          38NPI                9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                          51PAYMENT NUMBER      999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, XX  XXXXX-XXXX                                           50PAYMENT DATE       MM/DD/CCYY


66REMARK CODE   66DESCRIPTION

99999        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
99999        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
99999        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
99999        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
```

Figure 22 – RA Summary Page (Part 1 of 2)



```
REPORT:   CRA-SUMM-R                          Indiana Core MMIS                    DATE:  MM/DD/CCYY
  RA#:    999999999                  <Financial Cycle Description>                PAGE:      9,999
PAYER :   XXXX                          PROVIDER REMITTANCE ADVICE
                                                SUMMARY

56 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                49 PAYEE ID      999999999999999
   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                         38 NPI               9999999999
   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                         51 PAYMENT NUMBER     999999999
   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, XX  XXXXX-XXXX                         50 PAYMENT DATE       MM/DD/CCYY

                                          ----------------------------------------CLAIMS DATA----------------------------------------

                                          CURRENT          CURRENT        MONTH-TO-DATE   MONTH-TO-DATE     YEAR-TO-DATE   YEAR-TO-DATE
                                          NUMBER           AMOUNT           NUMBER          AMOUNT            NUMBER         AMOUNT
  A CLAIMS PAID                           999,999       99,999,999.99       9,999,999    999,999,999.99       9,999,999    999,999,999.99
  B CLAIM ADJUSTMENTS                     999,999       99,999,999.99       9,999,999    999,999,999.99       9,999,999    999,999,999.99
  C CLAIMS INTEREST                                     99,999,999.99                    999,999,999.99                    999,999,999.99
    D TOTAL CLAIMS PAYMENTS               999,999       99,999,999.99       9,999,999    999,999,999.99       9,999,999    999,999,999.99
  E CLAIMS DENIED                         999,999                           9,999,999                         9,999,999
  F CLAIMS IN PROCESS+                    999,999       99,999,999.99

                                          ----------------------------------------EARNINGS DATA----------------------------------------
PAYMENTS:
  G CLAIMS PAYMENTS                                     99,999,999.99                    999,999,999.99                    999,999,999.99
  H MANAGED CARE ADMINISTRATIVE PAYMENT*                99,999,999.99                    999,999,999.99                    999,999,999.99
  I HOOSIER HEALTHWISE CAPITATION PAYMENT*              99,999,999.99                    999,999,999.99                    999,999,999.99
  J HEALTHY INDIANA PLAN POWER ACCOUNT*                 99,999,999.99                    999,999,999.99                    999,999,999.99
  K HEALTHY INDIANA PLAN CAPITATION PAYMENT*            99,999,999.99                    999,999,999.99                    999,999,999.99
  L PAYOUTS                                             99,999,999.99                    999,999,999.99                    999,999,999.99
    ACCOUNTS RECEIVABLE:
    M CLAIM SPECIFIC:
        CURRENT CYCLE                                  (99,999,999.99)                  (999,999,999.99)                  (999,999,999.99)
        OUTSTANDING FROM PREVIOUS CYCLES               (99,999,999.99)                  (999,999,999.99)                  (999,999,999.99)
    N NON-CLAIM SPECIFIC                              (99,999,999.99)                  (999,999,999.99)                  (999,999,999.99)
    O ADVANCEMENT RECOVERIES                           (99,999,999.99)                  (999,999,999.99)                  (999,999,999.99)

REFUNDS:
      P CLAIM SPECIFIC ADJUSTMENT REFUNDS             (99,999,999.99)                  (999,999,999.99)                  (999,999,999.99)
      Q NON CLAIM SPECIFIC REFUNDS                    (99,999,999.99)                  (999,999,999.99)                  (999,999,999.99)
```

Figure 22 – RA Summary Page (Part 2 of 2)



OTHER FINANCIAL:

R MANUAL PAYOUTS	99,999,999.99	999,999,999.99	999,999,999.99
S VOIDS	(99,999,999.99)	(999,999,999.99)	(999,999,999.99)
T MEMBER CONTRIBUTION (POWER)	(99,999,999.99)	(999,999,999.99)	(999,999,999.99)
U NET PAYMENT**	99,999,999.99	999,999,999.99	999,999,999.99
V NET EARNINGS	99,999,999.99	999,999,999.99	999,999,999.99

OUTSTANDING CHECKS

W CHECK NUMBER	X ISSUE DATE	Y ISSUE AMOUNT
999999999	MM/DD/CCYY	99,999,999.99
999999999	MM/DD/CCYY	99,999,999.99
999999999	MM/DD/CCYY	99,999,999.99

THE CHECK NUMBERS LISTED REMAIN OUTSTANDING. PLEASE CASH THE CHECK(S), OR CONTACT PROVIDER SERVICES IF THERE IS A PROBLEM.

** NET PAYMENT AMOUNT HAS BEEN REDUCED. LIEN PAYMENTS HAVE BEEN MADE TO THE FOLLOWING LIEN HOLDERS:

PAYMENTS TO LIEN HOLDERS

Z LIEN HOLDER NAME	ZZ LIEN AMOUNT
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	9,999,999.99
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	9,999,999.99
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	9,999,999.99
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	9,999,999.99
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	9,999,999.99

† THIS AMOUNT REPRESENTS THE BILLED AMOUNT.
* MANAGED CARE ADMINISTRATIVE PAYMENT FOR THE MONTH OF MM/YY. PLEASE REFER TO YOUR ADMINISTRATIVE PAYMENT LISTING FOR ADDITIONAL DETAIL.
* HOOSIER HEALTHWISE CAPITATION PAYMENT FOR THE MONTH OF MM/YY. PLEASE REFER TO YOUR CAPITATION PAYMENT LISTING FOR ADDITIONAL DETAIL.
* HEALTHY INDIANA PLAN POWER ACCOUNT PAYMENT FOR THE MONTH OF MM/YY. PLEASE REFER TO YOUR 820 FOR ADDITIONAL DETAIL.
* HEALTHY INDIANA PLAN CAPITATION PAYMENT S FOR THE MONTH OF MM/YY. PLEASE REFER TO YOUR 820 FOR ADDITIONAL DETAIL.

Comparison of the 835 Transaction and Remittance Advice

The RA reports only dollar amounts without balancing concerns. This dollar amount reflects prior payment information, including TPL and Medicare payments, or Medicare coinsurance, copayment, or deductible as submitted with the original claim.

The CAS segments of the 835 transaction use different methods of reporting adjustments. Per the Data Overview Section of the *005010X221 – 835 Health Care Claim Payment/Advice Transaction, Version 5010 Implementation Guide Section 1.10.1.4 – Remittance*, "The 835 must be balanced whenever remittance information is included in an 835 transaction." *Section 1.10.2.1 – Balancing*, in the same section of the *835 Implementation Guide*, states, "The amounts reported in the 835, if present, MUST balance at three different levels." Because the guide does not address the issue of populating the 835 CAS segments, the decision was made to use the method described in the 4050 draft version of the 835 guide. Per this guide, the IHCP reports, for balancing purposes, only the amount of prior payment, TPL, and Medicare payments or Medicare coinsurance, copayment, or deductible in the 835 transaction, up to the amount that would have been paid for the service.

Accounts Receivable, Financial Transactions, and Other Provider-Level Adjustments

An accounts receivable (A/R) is money determined by the State or one of its contractors to be payable to the IHCP from an enrolled provider. A/Rs may also occur when a provider has adjusted a claim or requested a claim adjustment.

Establishing Accounts Receivable

*Core*MMIS automatically establishes a separate A/R for *every* adjustment when the net reimbursement of an adjustment is less than the original payment. For all system-generated A/Rs, the ICN/Claim ID of the original claim, the member name, and Member ID (formerly known as RID) are also reflected on the RA.

The second method for establishing an A/R is manual setup. Common reasons for manual setups are repayment agreements, tax assessments for intermediate care facility for individuals with intellectual disabilities (ICF/IID) and community residential facility for the developmentally disabled (CRF/DD), quality assessments for nursing facilities, hospital assessment fees, and Surveillance and Utilization Review (SUR) audits.

Accounts Receivable Reason Codes

Table 5 lists the reason codes associated with establishing an A/R. The most commonly used codes are **bolded.**

Table 5 – Accounts Receivable Reason Codes

Code	Description
8400	**A/R – Result of claim adjustment**
8401	A/R – Manual setup (SURs) less than 1 year
8402	A/R – Manual setup (Fraud)
8403	A/R – Manual setup (Waiver)
8404	A/R – Manual setup (IFSSA)
8405	**A/R – Manual setup (Tax Assessments-Monthly)**
8406	**A/R – Manual setup (Unspecified)**
8407	A/R – Manual setup (Converted AR nonrisk)
8408	A/R – Manual setup (TPL special project)
8409	A/R – Manual setup (Drug rebate)
8410	A/R – Manual setup (SURs interest) less than 1 year
8411	A/R – Manual setup (Claims older than 3 years)
8412	A/R – Manual setup (Check partial payments)
8413	A/R – Manual setup (Check partial payments – Risk related)
8414	A/R – Manual setup (Returned meds from nursing facility)
8415	A/R – Manual setup (Indiana State Department of Health [ISDH] civil penalties)
8416	**A/R – Result of retro-rate adjustment**
8417	A/R – Manual setup (Banning of new admissions)
8418	A/R – Manual setup (Overpayments identified by long-term care auditor)
8419	A/R – Manual setup (Transfer of account)
8420	A/R – Result of claim adjustment (Risk)
8421	A/R – Manual setup (Tax assessment rate increase)
8422	A/R – Manual setup (Payment Integrity Program [PIP])
8423	A/R – Manual setup (PIP Interest)
8424	A/R – Manual setup (IFSSA, risk related)
8425	A/R – Manual setup (Pharmacy benefit manager [PBM])
8426	A/R – Manual setup (PBM interest)
8427	A/R – Manual setup (Converted AR risk)
8428	A/R – Manual setup (1994-98 tax assessment reconciliation)
8429	A/R – Manual setup (Monthly tax assessment reconciliation rate)
8460	A/R – Manual setup (Pre-Admission Screening Resident Review [PASSR])
8461	A/R – Manual setup (Medical Review Team [MRT])
8462	A/R – Manual setup (Hoosier Rx)
8463	**A/R – Manual setup (Nursing facility monthly quality assessment)**
8464	A/R – Manual setup (Nursing facility quality assessment rate increase)
8467	A/R – Manual setup (Claims analysis and recovery [CAR])
8468	A/R – Manual setup (CAR interest)

Code	Description
8469	A/R – Result of Community Alternatives – Psychiatric Residential Treatment Facility (CA-PRTF) claim adjustment
8470	A/R – Result of CA-PRTF claim adjustment (Risk)
8471	A/R – Result of CA-PRTF retro rate adjustment
8472	A/R – Result of Money Follows the Person (MFP) claim adjustment
8473	A/R – Result of MFP claim adjustment (Risk)
8474	A/R – Result of MFP retro rate adjustment
8475	A/R – Manual setup (CA-PRTF)
8476	A/R – Manual setup (MFP)
8488	A/R – Result of medical education adjustment
8490	A/R – Manual setup (Medical education)
8491	A/R – Manual setup (Recovery Audit Contractor [RAC] audit)
8492	A/R – Manual setup (RAC audit interest)
8493	A/R – Result of Electronic Health Record (EHR) incentive payment adjustment
8494	**A/R – Manual setup (Monthly Hospital Assessment Fee)**
8495	A/R – Manual setup (Hospital Assessment Fee inc.)
8496	A/R – Result of claim adjustment (Department of Correction [DOC] inmate)
8497	A/R – Manual setup (DOC inmate)
8528	A/R – Result of RAC audit adjustment – less than 1 year
8529	A/R – Result of RAC audit adjustment – greater than 1 year
8554	A/R – Result of SUR audit adjustment – less than 1 year
8555	A/R – Result of SUR audit adjustment – greater than 1 year
8573	A/R – Manual setup (RAC audit greater than 1 year)
8574	A/R – Manual setup (RAC audit interest greater than 1 year)
8575	A/R – Manual setup (SUR audit greater than 1 year)
8576	A/R – Manual setup (SUR audit interest greater than 1 year)
8577	A/R – Manual setup (provider evaluation overpayment)
8578	A/R – Manual setup (provider vaccine administration overpayment)

Recovery of Accounts Receivable

The following four methods are used to recoup A/Rs:

1. The first method is the claim offset process, which occurs when a provider filing a claim for reimbursement has a portion of the amount owed on the A/R systematically deducted from its weekly RA payment until the full amount is recouped. When the A/R is systematically created by *Core*MMIS or manually by the financial analyst, a recoupment date is established that is the effective date for recoupment. Based on this information, *Core*MMIS automatically begins deducting payment from the provider's RA.
2. The second method occurs when a provider recognizes that an overpayment exists and sends a refund check to offset the A/R. When submitting a refund check, the provider must refer to any applicable ICNs/Claim IDs, member identification numbers, member names, and A/R control numbers to ensure proper handling.
3. The third method for recovery of A/Rs involves a repayment agreement between the IHCP and the provider owing money to the State. This repayment agreement allows the provider to make installment payments for up to, but not more than, a 6-month period to refund the State for overpayments. This method typically occurs only when the provider owes especially large sums of money causing financial hardship, and alternate sources of outside financing have been unsuccessful. The Family and Social Services Administration (FSSA) must approve each repayment agreement. See the *Partial Payments and Repayment Agreements* section for instructions on how to submit a repayment agreement request.

   Note: Each provider and service location can have only one open repayment agreement at a time.

4. The fourth method is used when an A/R is established under the Provider ID and it is determined that the number is not actively enrolled in the IHCP. If other Provider IDs share the same taxpayer identification number (tax ID), the A/R is transferred to the active Provider IDs. This action may also occur voluntarily when a provider requests the account be transferred to another active Provider ID.

Accounts Receivable Referrals

If an A/R has not been recovered after 15 days, the Finance Unit mails either a transfer letter or a demand letter, as follows:

- Transfer letter (Figure 23) – If the provider with the outstanding A/R shares a common tax ID with another provider, the Finance Unit mails a **transfer letter** to the pay-to address of the Provider ID with the same tax ID, as notification that the A/R will be transferred to that provider. If the recipient of the transfer letter does not respond in 10 days, the A/R is transferred to that provider to recoup the amount owed.
- Demand letter (Figure 24) – If the provider with the overdue A/R does not share a common tax ID with another provider, the Finance Unit mails a **demand letter** to the provider's pay-to address. If the provider was issued a demand letter and the A/R is still open after 15 days, a request for a referral to the Office of the Attorney General may be sent to the FSSA. To avoid referrals to the Office of the Attorney General for legal action, providers must remit payment within 15 days of receipt of the demand letter.

Figure 23 – Transfer Letter

Eric Holcomb, Governor
State of Indiana

Indiana Health Coverage Programs

DXC TECHNOLOGY FINANCE UNIT
950 NORTH MERIDIAN STREET, SUITE 1150
INDIANAPOLIS, IN 46204

800-457-4584
www.indianamedicaid.com

<Date>

<Provider Name>
<Pay-to Address>

Re: Outstanding Accounts Receivable

Dear Provider,

Our records indicate that your **Tax Identification Number <*Tax ID*>** has outstanding accounts receivable under **<*Provider ID (with outstanding A/R)*>**. Although these receivables were established under a different Provider ID, your tax entity remains responsible for this repayment.

DXC is prepared to transfer the accounts receivable amount of **$<*amount*>** to your Provider ID **<*Provider ID (recipient of letter)*>**. Please contact our office to discuss this matter and its resolution. If our office does not hear from you within **10 calendar days** from the date of this letter, the transfer will occur automatically on **<*date*>**. Once this transfer occurs, the amount will be deducted from future remittance advices until the account(s) receivable is satisfied.

Your assistance in resolving this matter is appreciated. Please contact the DXC Finance Unit at (317) 488-5004, should you have any questions regarding this letter.

Sincerely,

Finance Unit

Children's Health Insurance Program ▪ Healthy Indiana Plan ▪ Hoosier Care Connect
Hoosier Healthwise ▪ M.E.D. Works ▪ Traditional Medicaid

Figure 24 – Demand Letter (Page 1 of 2)

Eric Holcomb, Governor
State of Indiana

Indiana Health Coverage Programs

DXC TECHNOLOGY FINANCE UNIT
950 NORTH MERIDIAN STREET, SUITE 1150
INDIANAPOLIS, IN 46204

800-457-4584
www.indianamedicaid.com

<Date>

<Provider Name>
<Pay-to Address>

Provider ID: <Provider ID>
Re: Outstanding Account(s) Receivable

Dear Provider,

This letter is a follow-up to a previous remittance advice sent regarding the outstanding account(s) receivable (A/R) under ***<Provider ID>***. If you bill on a regular basis, the money will be recouped from your future payments until satisfied. You are receiving this letter because there has been insufficient submission of claims at this time. The full amount of the outstanding account(s) receivable is ***$<amount>.***

If you do not bill regularly and the repayment activity has not occurred on this account(s) receivable within the required period, you need to send a check to the address below. This letter serves as an official request for the repayment of the outstanding balance of your account(s) receivable. Please remit payment for ***$<amount>*** and a copy of this letter to the following address:

Accounts Receivable
DXC Technology Finance Unit
950 N. Meridian Street, Suite 1150
Indianapolis, IN 46204-4288

Responses should be postmarked no later than **10 calendar days** from the date of this letter, on which date your complete provider file and enrollment packet will be prepared for transfer to the Office of Medicaid Policy and Planning (OMPP) within three business days. It is the intent of the OMPP to make a referral to the Office of Indiana Attorney General for collection. Any documentation that will conclusively refute the amount owed must be submitted prior to the date above.

A survey is included on the back of this letter for you to indicate the status of your receivable. If you are currently working with DXC staff to resolve outstanding issues, please be aware that we will complete that work before any case is referred for collection. If your receivable has already been satisfied prior to your receipt of this letter, you do not need to respond to this letter.

A survey is included on the back of this letter for you to indicate the status of your receivable.

Your assistance in resolving this matter is appreciated. Please contact the DXC Finance Unit at (317) 488-5004, should you have any questions regarding this letter.

Sincerely,

Finance Unit

Children's Health Insurance Program ▪ Healthy Indiana Plan ▪ Hoosier Care Connect
Hoosier Healthwise ▪ M.E.D. Works ▪ Traditional Medicaid

Figure 24 – Demand Letter (Page 2 of 2)

PLEASE INDICATE BELOW THE CURRENT STATUS OF YOUR RECEIVABLE:

☐ Check enclosed, $_____.

☐ Check will be sent by _____. (Date check will be mailed.)

☐ Working with DXC Finance Unit, _____ (Analyst Name)

☐ Working with DXC Field Consultant, _____ (Consultant Name)

☐ Transfer to *ACTIVE* Provider ID: _____

☐ Corporation dissolved as of _____ (Date of Dissolution).
Forward a copy of the corporation dissolution documentation.
Owner's Name and Telephone Number: _____

☐ Corporation has been sold as of _____ (Date of Sale).
Forward a copy of the Purchase Agreement.

☐ Previous owner's name/telephone number:

_____

☐ Current owner's name/telephone number:

_____

☐ Bankruptcy filed as of _____ (Date), filed in _____ County. Provide a copy of the Bankruptcy Notice.

☐ Provider deceased as of _____ (Date). Please supply a copy of the death certificate and additional documentation if the Estate is open.

☐ Retired as of _____ (Date).

☐ Contact name/telephone number:

_____

Name/Title/Telephone Number of Person Completing Form:

_____

_____

Date: _____

Return form to Accounts Receivable, DXC Technology Finance Unit, 950 N. Meridian Street, Suite 1150, Indianapolis, IN 46204-4288.

Additional Provider-Level Adjustments

Additional adjustments are listed and explained in the following sections. These financial transactions are reported in the Financial Transactions section of the RA and under the appropriate headings on the Summary page of the RA. Within the electronic 835 transaction format, these financial transactions are reported at the provider level using the financial ARCs and may only appear when they are applied or when claim activity is present.

ICF/IID Tax Assessments

Monthly, ICF/IID and CRF/DD facilities are charged a tax assessment. Myers and Stauffer determines the assessment in conjunction with the rate-setting process and forwards the information to the Finance Unit along with the rate for a given period.

The monthly assessment appears as an A/R with the reason code of 8405. Within the 835 transaction, the A/R appears as a provider-level adjustment with a FIN ARC assigned to the amount.

When the Finance Unit receives retroactive notification of a rate change, the notification also provides the change in the tax assessment amount. When the change is received, the Finance Unit reconciles the amount due based on the rate change to the amount collected. Based on an increase or decrease in the assessment amount, the Finance Unit initiates an A/R to collect additional money due if the assessment increased or a payout to return money over collected if the assessment decreased.

Payouts

Payouts occur when providers are due refunds from the IHCP that cannot be tied to a specific claim transaction. Payouts are initiated any time refunds are due to providers but the refunds cannot be tied to specific claims. Reasons for refunds include, but are not limited to the following:

- Overpayments when a provider submits a check after claims are offset
- Repayment agreements approved by the FSSA

Except in the instances of partial provider payments and repayment agreements, payout requests are initiated by the Finance Unit, Myers and Stauffer, or the FSSA, and do not require the provider to submit any additional documentation or requests. For more information on requesting provider partial payments, see the *Partial Payments and Repayment Agreements* section.

Payouts are listed on the Financial Transactions page of the weekly RA under non-claim-specific payouts. A transaction number is listed for each payout, which is an internal tracking number and should be referred to when calling the Customer Assistance Unit for more information. Within the 835 transaction, payouts are also assigned a FIN ARC as a provider-level agreement.

Next to the payout amount in the non-claim-specific payout section of the RA is a reason code that identifies why a payout was made to a provider. The following is a list of the most common reason codes:

- 8302 – *Payout Due to an Over Refund*. This reason code indicates that a provider issued a check to the IHCP to refund monies the provider believed were due to the IHCP. However, the check was in excess of the actual amount due, and the payout is initiated to return excess monies to the provider. Payouts using this reason code also display a number under the CCN field, which reflects the CCN assigned to the provider's refund check when the Finance Unit received it.
- 8304/8305 – *Payout Due to a Partial Payment*. These reason codes indicate that a partial provider payment and repayment agreement have been requested and approved by the FSSA. If reason code 8304 is displayed, the partial payment monies are included in the total amount being paid to the provider in this weekly RA. If reason code 8305 displays, the provider previously received a manual check, outside the RA, for the partial payment of monies.

- 8306 – *Check Received by HP for Claim Adjustment on Previously Adjusted Claim*. *Amount of Refund Being Returned to Provider*. This reason code is used when the Finance Unit receives a refund from a provider that cannot be applied because the corresponding claim has already been adjusted. The refund is returned to the provider.

Payouts are included in the provider's net earnings for the year and are reflected in *1099* reporting to the provider and the IRS.

Partial Payments and Repayment Agreements

A partial payment and repayment agreement may be issued to a provider at the direction of, or after approval by, the FSSA when a provider has proven that significant claim-processing issues are causing undue financial hardship and alternate sources of outside financing have been unsuccessful. Repayment agreements may be the result of, but are not limited to, mass adjustments and retro-rate adjustments.

The maximum amount that a provider may request for a repayment agreement is five-sixths of the total amount owed, to be repaid over a maximum of 6 months. If the provider is requesting a 5-month repayment agreement, the maximum partial payment to the provider is four-fifths of the total amount owed, and so forth.

A provider may have only one repayment agreement per Provider ID at any given time.

The following steps outline the process for establishing a repayment agreement:

1. To request a repayment agreement, the provider must mail or fax a letter on the provider's letterhead to the DXC Finance Unit:

   Finance Manager
   DXC Technology Finance Unit
   950 North Meridian Street, Suite 1150
   Indianapolis, IN 46204-4288

   Fax: (317) 488-5038

   The letter must contain the following information:
   - Provider name
   - Provider ID
   - Provider *pay-to* address

   Note: The pay-to address must match the information currently displayed in CoreMMIS. If there is a discrepancy, the provider must update this information before any further actions occur.

   - Provider contact name, title, and telephone number
   - Reason for the request of a repayment agreement detailing specific reasons for financial hardship
   - Length of desired agreement (not to exceed 6 months)
   - Amount of the requested agreement
   - Statement indicating the facility has attempted to secure funds from its lending institution for this amount

   Note: A copy of the declination letter from the financial institution must be included with the submission.

   - Detailed and specific account of the reasons for the request
   - Statement as to the status of a pending action, including a change of ownership (CHOW), bankruptcy filing, or facility closing that is currently taking place or may occur within the 6 months following the date of the request
   - Copy of the provider's latest financial statement or cost report

2. After receiving the written request, the Finance Unit performs a review of the information.
3. Upon verifying compliance with the required conditions, the Finance Unit drafts a repayment agreement and submits it to the FSSA for review.
4. The FSSA makes a determination to approve or deny the agreement:
   - If the FSSA does not grant approval for a repayment agreement, the Finance Unit contacts the provider regarding the denial.
   - If the FSSA grants approval and returns the fax of the agreement, with signature, the Finance Unit faxes a copy of the agreement to the provider to sign.
5. The provider signs the approved agreement and returns it by mail or fax to the Finance Unit.
6. Upon receipt of the signed copy from the provider, the Finance Unit executes the agreement.

Figure 25 shows an example of a payment and recoupment agreement.

Figure 25 – Payment and Recoupment Agreement (Page 1 of 2)

Indiana Health Coverage Programs (IHCP) Payment and Recoupments Agreement
For <*Provider ID*>

NOTE TO PROVIDERS: This request cannot be considered or executed without a written request submitted to DXC Technology on the provider's letterhead detailing the rationale for its request for a repayment agreement. The Office of Medicaid Policy and Planning (OMPP) will consider each request based on the information provided. The IC 12-15-23-2 is the authority for entering into agreements to deduct overpayments from subsequent payment. ***The terms of such agreements can never exceed six months and interest must be collected. See 405 IAC 1-1-5(g).***

____ A) This repayment agreement is for a system offset
____ B) This repayment agreement is for manual (check) reimbursement

This agreement has been entered into by ***<Provider Name, Address, City, State, ZIP>*** (hereinafter "Provider") and the Office of Medicaid Policy and Planning, State of Indiana (hereinafter OMPP) through its fiscal contractor, DXC Technology (hereinafter DXC), 950 N. Meridian, Suite 1150, Indianapolis, Indiana 46204-4288.

By execution of this Agreement, the undersigned Provider agrees to the payment terms and conditions specified herein.

The Terms and Conditions of this Agreement are as follows:

1. The Provider has requested a payment plan based upon future Medicaid payments in the amount of $***<amount>*** for the reason set forth on the Provider Payment Plan Form (attached and incorporated herein by reference). The OMPP has approved said request.

2. _____ **A) System Offset:** The Provider agrees to permit DXC to begin recoupment of the monies owed against its Medicaid payments on ***<date>***. Such recoupments shall take place against remittances issued to the Provider beginning on ***<date>*** until the payment is fully recouped. At this rate, the entire payment will be recouped by <***date***>. The provider agrees to permit DXC to automatically recoup all outstanding manual reimbursement for accounts receivables setup that are greater than 15 days old under this agreement. **If full payment is not received within 15 calendar days from the due date, the agreement will be placed in default and subject to immediate and full recoupment.**

   _____ **or B) Manual Payment:** The Provider agrees to begin repayment to the OMPP (via DXC) of the monies owed against its Medicaid payments on ***<date***>. Such payments shall take place ***<rate (monthly, weekly, etc.)>*** beginning on ***<date>*** until the payment is fully recouped. At this rate, the entire repayment will be made by ***<date>***. DXC should receive payment on or before the due date. If payment is not received within 15 calendar days from the due date, the agreement will be placed in default and subject to immediate and full recoupment.

3. The Provider agrees that if the recoupment has not been completed by ***<date>***, the remaining balance is immediately due and that the Provider shall remit the full balance to DXC by ***<date>*** (*10 days after the expected full recoupment date*). If payment is not received once the accounts receivable has aged 15 days and the provider is submitting claims for payment, DXC will begin offsetting dollars at 100 percent until payment is fully recouped.

4. The Provider shall immediately notify DXC Provider Enrollment of any change in address, location, provider number, or status of ownership or control of the undersigned entity. If the OMPP is notified that the facility will be closing or if the provider will no longer be submitting claims under Provider ID***<Provider ID>***, as a result of the closure, change of ownership (CHOW), or control of the undersigned entity, the Provider agrees to remit the outstanding balance of the payment to DXC or DXC shall begin offsetting the total balance beginning with the claims immediately following such notice or CHOW.

5. The Provider agrees that should it file a bankruptcy petition at some future date before recoupment of this payment in accordance of this agreement is complete, recoupment in accordance with this agreement shall be considered an equitable exception from the automatic stay under *11 U.S.C. 362.* The provider shall not oppose any action by the OMPP to continue recoupment.

Repayment Agreement - Page 1 of 2
Date: <***date***>
Provider ID <***Provider ID***>

Figure 25 – Payment and Recoupment Agreement (Page 2 of 2)

Indiana Health Coverage Programs (IHCP) Payment and Recoupments Agreement
For <*Provider ID*>

6. Should the business submitting claims as Provider #**<*Provider ID*>** cease to exist as a legal entity due to a change in ownership status, Provider #**<*Provider ID*>** shall be responsible for any current and future liabilities that may result from retro-rate adjustments or any other accounts receivable that are the subject of this agreement unless the new owner agrees in writing to be liable for any amounts due the State of Indiana. The Provider may not assign or transfer the Provider's liabilities under this agreement without the prior written consent of the OMPP. In the absence of evidence of such a written agreement between the Provider and the new owner, the Provider's owners, corporate officers, and/or Board of Directors agree that they are jointly and severally liable for repayment of any and all liabilities arising from the relationship between the Provider and Indiana Medicaid.

7. Should the business submitting claims as Provider **#<*Provider ID*>** default on any terms of this agreement or fail to repay the full amount by **<*date*>**, the provider agrees to pay any costs of collection including, but not limited to, attorney fees and court costs.

8. The Provider and the OMPP agree that any modifications to this agreement shall only be made in writing and signed by both parties.

WHEREOF, the parties have executed this Agreement.

To be completed/signed by Provider	**To be signed by DXC**	**To be signed by OMPP**
Provider Representative Signature*	DXC Director Signature	OMPP Representative Signature
Provider Representative Printed Name	DXC Financial Analyst Signature	OMPP Representative Printed Title
Provider Representative Printed Title/Contact Phone Number		
Company Name DBA		
Company Corporate/Legal Entity (if different from above DBA)		
Address Corporate/Legal Entity		
Tax ID Legal Entity (if different from provider tax ID)		
Date	Date	Date

The individual signing this form must be an employee or officer who can legally bind the company to this agreement.

FOR DXC USE ONLY

Date Received	Initial Analyst Assigned	All Documentation Included?	Proceed with Repayment Agreement?
		☐ Yes ☐ No	☐ Yes ☐ No

Repayment Agreement - Page 2 of 2
Date: <***date***>
Provider ID <***Provider ID***>

Non-Claim-Specific Refunds

Money repaid by a provider that cannot be tied to a specific claim is considered a non-claim-specific refund. A provider can return money not related to a specific claim for the following items:

- A/R repayments
- SUR audits when the random sampling method was used to identify the overpayment
- Provider's internal audit identifies IHCP overpayments, but specific claims cannot be identified

Next to the refund amount in the non-claim-specific refunds section of the RA is a reason code that identifies how a non-claim-specific refund was applied. In the electronic 835 transaction, these refunds appear assigned to FIN ARCs as provider-level adjustments. The following is a list of the most commonly used reason codes:

- 8220 – *Refund due to Third Party Liability*. If the provider indicates that a refund is due the IHCP after payment is received from a third party, this reason code is used.
- 8223 – *Surveillance Utilization Review (SUR) Audit*. If the provider indicates a repayment of the principal owed on a SUR audit finding, this reason code is used. SUR audit refunds are only non-claim-specific when the random sampling method is used. If a SUR audit finds specific claims to be repaid, those refunds are posted as claim-specific. The *Claim Adjustments* module provides more information on claim-specific adjustments.
- 8224 – *SUR Interest.* If the provider indicates a repayment of the interest due on a SUR audit finding, this reason code is used.
- 8438 – *A/R Repayment*. If the provider indicates a repayment of an outstanding A/R, this reason code is used.
- 8229 –*Non-claim Refund-Unspecified.* Refund check with insufficient documentation to apply to a given claim was received from a provider. A check was applied against a provider's earnings but not to a particular claim.

Non-claim-specific refunds are deducted from the provider's net earnings for the year and are reflected on *1099*s.

Liens against Provider Payments

The Finance Unit is responsible for handling liens against provider payments. These liens originate from the IRS or court orders. The Finance Unit enters the liens in *Core*MMIS. As a result, providers can see net payments reduced by the amount of the lien, or the entire amount due can be forwarded to the lien holder.

The Finance Unit receives notification from the IRS by a Notice of Levy or by a court order for garnishments. When it receives such notification, the Finance Unit identifies all providers that share the tax ID affected by the lien. The amount of the lien is entered in *Core*MMIS and payments are forwarded to the lien holder until the full amount of the lien has been satisfied, the lien has been released, or the lien requirements have been satisfied.

Liens appear on the RA *Summary* page under the *Payments to Lien Holders* section. The lien holder's name and the amount paid to the lien holder in the current cycle are included in this section. On the 835 electronic transaction, the lien amount appears only as the current paid amount whenever present as a provider-level adjustment using a financial ARC.

An additional provider-level adjustment that can occur is a backup withholding. If a provider is subject to backup withholding, the information displays in the *Payments to Lien Holders* section of the RA *Summary* page. More information on the backup withholding process is included in the *Internal Revenue Service Reporting Requirements* section. In the 835 transaction, backup withholding appears as a current provider-level adjustment with an assigned financial ARC only.

While payments can be made to the lien holders, the provider's *1099* reflects the full amount of all net payments regardless of any amounts forwarded to lien holders.

For a provider to be released from a lien, one of the following must occur:

- The full amount of the lien must have been collected and forwarded to the lien holder.
- If it is an IRS-ordered lien, the Finance Unit may receive a Release of Lien from the IRS for a continuous levy or may close the lien after the levy requirements have been satisfied.
- If it is a court-ordered lien, the Finance Unit must receive a court order indicating that any court order of garnishment can now cease.

IHCP Payment Check Processing

Each week, the Finance Unit compiles claim payments and non-claim-specific transaction information processed by *Core*MMIS and issues an RA or 835 transaction to the provider. If a payment is due to the provider and the provider is not using EFT, an IHCP payment check is sent by U.S. Mail. See the *Electronic Funds Transfer* section or more information on how to enroll for EFT payments.

This section describes the actions that can occur after the IHCP payment check is issued. These actions include the following:

- Stop payment and reissue of IHCP payment checks
- Stale-dating of IHCP payment checks
- Voiding of IHCP payment checks

Stop Payment and Reissue Requests

Occasionally, a provider may not receive an IHCP payment in a timely manner, and a check reissue is required. In this situation, a stop-payment request is appropriate. Providers should allow 2 weeks (14 calendar days) before submitting a reissue request to allow for delivery delays from the U.S. Postal Service. The following steps describe the stop-payment and reissue process.

1. The provider calls the Customer Assistance Unit toll-free at 1-800-457-4584 to request that an IHCP check be reissued.

   Providers must be prepared to confirm the *pay-to* address when requesting that an IHCP payment be reissued. DXC will not reissue a check or an EFT in the event that the *pay-to* address listed in *Core*MMIS is incorrect. To have the *pay-to* address updated, providers must submit an *IHCP Provider Name and Address Maintenance Form* (available from the *Update Your Provider Profile* page at in.gov/medicaid/providers) or use the Portal to update their information on file. This update is important to ensure that the check can be reissued and that future checks are delivered promptly.
2. After receiving the reissue request, the Finance Unit verifies the records to determine whether the check was returned to DXC to be voided. If the check was returned to DXC with instructions to be voided, all claims associated with that check were voided. The provider must resubmit relevant claims to adjudicate claims. Checks that are voided cannot be reissued.
3. If the Finance Unit does not have a record of the check being returned as undeliverable or voided, DXC notifies the bank to stop payment on the original check number.
4. If the original check has not been presented for payment and honored by DXC's bank, the bank places a stop payment on the check.
5. DXC reissues the payment with a different check number and forwards the reissued check to the provider. Again, the *pay-to* address must be confirmed and correct before a check can be reissued.

If the provider receives the original check after a reissuance has been requested, the provider should write *VOID PREVIOUSLY REQUESTED* on the front of the check and mail the original check to the following address:

DXC Finance Unit
950 N. Meridian St., Suite 1150
Indianapolis, IN 46204-4288

Providers are responsible for informing the Provider Enrollment Unit of all address changes through the *IHCP provider packet* or by using the Portal. Failure to update the information in a timely manner can result in delays in payment and can cause the provider to have to request a check reissuance. The *Provider Enrollment* module provides more information about address changes.

Providers are encouraged to consider EFT, which deposits IHCP payments automatically into the appropriate account each week. EFT prevents lost checks and decreases the time required to receive payments. More information about EFTs is included in the *Electronic Funds Transfer* section.

Stale-Dated Checks

Checks are issued and mailed to IHCP providers weekly. If a check is not presented for payment at DXC's bank within 6 months after the date of issuance, the check is stale-dated at the bank and will not be honored for payment. After a check becomes stale-dated, DXC voids the check and any associated claims from *Core*MMIS.

A provider in possession of a stale-dated check should write *VOID – STALE-DATED* across the face of the check and return it to the following address:

DXC Finance Unit
950 N. Meridian St., Suite 1150
Indianapolis, IN 46204-4288

After returning a stale-dated check to the Finance Unit, the provider must resubmit any claims paid with that check to DXC for processing to receive payment.

The administrative burden for the provider increases when a check becomes stale-dated. Providers are encouraged to cash checks in a timely manner to prevent stale-dating and to decrease resubmission of claims. An alternative to receiving checks, which also prevents stale-dating, is to enroll in the EFT option. The *Electronic Funds Transfer* section provides more information about EFT.

Voiding an IHCP Payment Check

A provider that receives an IHCP payment check and wants to return the entire amount can return the check for voiding to the following address:

DXC Finance Unit
950 N. Meridian St., Suite 1150
Indianapolis, IN 46204-4288

A provider can initiate voiding a check for a number of reasons. These reasons include, but are not limited to, the following:

- The members listed on the RA are not patients of the provider receiving the check.
- The wrong provider received the payment.
- The IHCP previously paid claims listed on the RA.
- The claims listed on the RA were paid for a provider not with the group that received payment.

- The payment was made payable to the wrong location or provider identification number.
- The check is older than 6 months from the date of issue and is stale-dated.

Claim adjustments do not require a check to be voided. A provider that has been overpaid or underpaid on a claim cannot return the check to be voided and reissued with a different dollar amount. The provider must submit an adjustment request as outlined in the *Claim Adjustments* module.

Voiding a check voids all transactions, including claims, associated with that check. When a check is voided, it cannot be stopped or replaced. The claims associated with that check must be resubmitted for processing. The void process removes the associated claim payments from the provider's *1099* amount.

Information about voided checks appears on the last page of the RA. The amount voided appears in the CURRENT AMOUNT column of the VOIDS line (under OTHER FINANCIAL). This amount is also added in the YEAR-TO-DATE column of this line. For *1099* reporting purposes, the voids are deducted from the provider's total year-to-date amount by subtracting the year-to-date VOIDS amount from the year-to-date NET PAYMENT amount.

Electronic Funds Transfer

Through EFT, IHCP payments are deposited directly into a provider's designated bank account, rather than being sent by paper check. EFT significantly reduces the amount of time providers must wait to receive payment for IHCP services. The Finance Unit deposits provider payments by electronic media in the bank account of the provider's choice. EFT eliminates mailing time from the Finance Unit to the provider's mailing address, manual deposit at the provider's bank, the possibility of the check being stale-dated because it was not deposited in a timely manner, and any delays crediting the funds to the provider's account that may be imposed by banking institutions. EFT is a safe, efficient, and cost-effective means of enhancing practice management accounts receivable (A/R) procedures.

The EFT is accomplished using Automated Clearing House (ACH) transactions from the IHCP's bank to the provider's bank. The ACH file that is sent to the provider's bank includes the ACH addenda record, per the recommendation outlined in the *835 Implementation Guide*. Providers can choose to accept the ACH addenda record from their banks. The *835 Health Care Claim Payment/Advice Transaction* companion guide on the *IHCP Companion Guides* page at in.gov/medicaid/providers includes the ACH value in BPR04 and CCP in BPR05 when the provider has EFT and also receives 835 transactions.

Providers participating in the EFT option receive RAs with printed check numbers beginning with **9**. Payments beginning with **9** on the RA have been directly deposited.

> *Note: Providers that use EFT continue to receive RA statements on the Portal. Providers that choose the 835 electronic transaction may select either paper check or EFT.*

How to Enroll in the IHCP Electronic Funds Transfer Option

EFT is only available for billing providers. Rendering providers do not have an EFT option.

Billing providers can establish EFT payments by entering their EFT information on the Portal (**My Home > Provider Maintenance > EFT Changes**). IHCP-enrolled providers can register for the Portal by selecting the Provider Healthcare Portal link from the home page of the IHCP provider website at in.gov/medicaid/providers and then clicking **Register Now**.

Alternatively, providers can submit a completed *IHCP Provider Electronic Funds Transfer Addendum/Maintenance Form*, available for download from the *Update Your Provider Profile* page at in.gov/medicaid/providers, to the Provider Enrollment Unit.

To start, cancel, or change EFT payments, providers must include the following on the EFT form:

- The correct provider profile information, including NPI, tax ID, and IHCP Provider ID (in the Assigning Authority field)
- The applicable financial institution information, including the bank's American Bankers Association (ABA) transit routing number
- A specific bank account number and the type of account, such as checking or savings
- The reason for submission (type of authorization being initiated): new enrollment, change enrollment, or cancel enrollment
- Signature of an authorized official or a delegated administrator listed with the Provider Enrollment Unit on a Schedule C.3 or a Delegated Administrator Addendum.

EFT forms must be submitted to the following address:

IHCP Provider Enrollment Unit
P.O. Box 7263
Indianapolis, IN 46207-7263

Providers should retain copies of the EFT forms for their records.

Note: It takes approximately 4 weeks for EFT information to be processed by DXC and validated by the provider's bank. Submitting an incomplete form delays the initiation, cancelation, or change of the EFT.

How an EFT Is Established with the Provider's Bank

When DXC receives and processes the completed form, *Core*MMIS sends a test transmission to the provider's bank. If the information in *Core*MMIS matches the information on the bank's records, EFT begins within three payment cycles.

If the information provided on the EFT form is not acceptable, the provider's bank sends an exception report to DXC. The report is verified against the provider's EFT form and *Core*MMIS for accuracy.

If the mismatch is a result of a keying error, DXC corrects the error and resumes testing. If the mismatch is a result of the information submitted by the provider, DXC contacts the provider to resolve the problem.

Until the EFT process is accepted by the providers' bank, providers continue to receive weekly IHCP payment checks.

EFT Rejections

EFTs routinely occur without intervention from the provider; however, providers are encouraged to verify with their banks each week that EFTs have been received. If EFTs have not been received by Thursday, providers should contact the Customer Assistance Unit toll-free at 1-800-457-4584.

While providers should verify deposit of the funds each week and can notify the Customer Assistance Unit of any problems, DXC is also notified by its bank if an EFT is not accepted by the receiving bank. The most common reasons EFTs are rejected are because of incorrect routing or ABA numbers, incorrect account numbers, the closure of the receiving account, or routing to a savings account when it is a checking account.

Confirm the ABA routing number that appears on a deposit ticket submitted with an EFT request before mailing the request to DXC or before entering the EFT information into the Portal. Deposit ticket routing numbers can vary from the actual routing number assigned to a customer's bank account. A deposit ticket

routing number that begins with a 5 should be questioned, and the bank should be contacted to verify the correct routing number related to the customer's account.

It is crucial for the provider to immediately update any change in bank information with the Provider Enrollment Unit to help prevent EFTs from being rejected. See the *How to Cancel EFT Participation or Change EFT Information* section. DXC cancels EFT information that caused a rejection so that future EFTs are not attempted using that information. When EFT is canceled, a provider receives a weekly check until the provider reapplies for EFT status.

When notified by its bank that the receiving bank has rejected an EFT, DXC requests that the amount of funds that should have been deposited via the EFT be reissued to the provider within the same week. Providers receive these funds by a separate check that indicates which EFT it is replacing.

How to Cancel EFT Participation or Change EFT Information

Billing providers can use the Portal or the *IHCP Provider Electronic Funds Transfer Addendum/ Maintenance Form* to start, cancel, or change an EFT. See the *How to Enroll in the IHCP Electronic Funds Transfer Option* section for more information on completing the form or making changes online.

After DXC processes the cancellation, providers will receive weekly IHCP payment checks.

> *Note: It takes approximately 4 weeks for EFT information to be processed by DXC and validated by the provider's bank.*

If a provider is changing EFT information, but not canceling EFT altogether, the provider should not close one EFT account until a second account has been activated, unless the provider changes its *pay-to* address to receive a payment check during the interim.

Refunds to the IHCP

If a provider owes money to the IHCP, the provider can write a check for the amount due and forward that check for processing. In some instances, as outlined in the *IHCP Payment Check Processing* section of this document, providers can choose to return the IHCP payment check uncashed.

Documentation Required

All checks issued as refunds to the IHCP must be accompanied by the appropriate documentation, such as a paid claim adjustment form or a copy of the RA showing the A/R being repaid. If proper documentation is not provided, the check can be incorrectly applied, or the provider can experience delays in posting a check while this documentation is obtained.

All checks issued as payment for products, such as provider modules, fee schedules, or software, must be accompanied by a purchase request.

IHCP providers must submit checks and associated documentation correctly for checks and check-related adjustments to process accurately and efficiently. DXC scans check-related adjustments. For documentation to be imaged clearly, completely, and correctly, observe the following guidelines:

- Do not highlight the member's name or other information on submitted documentation. When documentation is scanned, the scanned image appears in black and white only. Highlighted information appears blacked out on the scanned image and is not readable.
- Use an asterisk next to the claim to be adjusted. Other options include circling member information on the EOB or blacking out all information not related to the specific request.

- Do not staple the check to the documentation.
- Do not put adhesive notes on the documentation. When scanned, the note may cover up important information necessary to adjust the claim.
- When submitting more than one check and accompanying documentation, place the documentation for each check behind the check to which it relates. Include a cover sheet on the documentation to indicate the number of checks being submitted.

Where to Send Checks

Checks issued as repayments for monies owed the IHCP that are related to Program Integrity must be made payable to **IHCP** and mailed to the following address:

FSSA Program Integrity
P.O. Box 636297
Cincinnati, OH 45263-6297

Checks issued as repayments for amounts owed to the IHCP that are not related to Program Integrity must be made payable to **IHCP** and mailed to the following address (with the appropriate documentation specifying why the check is being submitted):

DXC Refunds
P.O. Box 2303, Dept. 130
Indianapolis, IN 46206-2303

Mail IHCP payment checks returned uncashed to be voided to the following address (include documentation as to why the check is being returned):

DXC Finance Unit
950 N. Meridian St., Suite 1150
Indianapolis, IN 46204-4288

Remit refund checks for pharmacy adjustments to the following address:

Courier Mail:

OptumRx Claims
LBX26594
JP Morgan Chase
131 S. Dearborn – 6th Floor
Chicago, IL 60603

First-Class Mail:

OptumRx Claims
26594 Network Place
Chicago, IL 60673-1265

If you have further questions regarding pharmacy, see the *Pharmacy Services* module.

> *Note: Do not send completed claim forms to these addresses for processing. Doing so results in processing delays. Mail completed claim forms to the appropriate post office box as outlined in the Claim Submission and Processing* module.

Internal Revenue Service Reporting Requirements

The IHCP is subject to the same rules and regulations as all other payers. As such, the program is required to report payments made to providers annually through the *1099* reporting process. Additionally, the program is required to perform backup withholding on provider payments if notification is given that information on the *1099* form does not match IRS records.

1099 Reporting

The IHCP is required to produce *1099s* for all entities that received more than $600 in payments in the prior calendar year. This information is reported to the IRS. Each *1099* must be postmarked by January 31 of each calendar year.

To determine what information is printed on the *1099* and reported to the IRS, *Core*MMIS accumulates all payments made to a given tax ID. These payments include claim-specific payments and non-claim-specific payouts.

The tax ID used in reporting is the one the provider supplied on the *W-9* form submitted with the *IHCP provider packet*. The name used for *1099* reporting is the *legal* name supplied on the same *W-9* form.

To prevent *1099* information from being reported incorrectly and to avoid the possibility of backup withholding, providers must update their IHCP provider profile information on a timely basis and confirm that the information currently on file is correct. Providers can obtain a copy of the *W-9* form from the *Update Your Provider Profile* page at in.gov/medicaid/providers or by contacting the IRS.

It is critical that providers do not allow other providers to submit claims using their provider numbers. Providers using the wrong provider number or allowing others to use the provider number may experience significant tax and accounts receivable problems at a later date.

1099 Correction Requests

A provider that receives an incorrect *1099* must request a review of the *1099* in writing at the following address:

Financial Analyst
DXC Finance Unit
1099 Processing
950 N. Meridian St., Suite 1150
Indianapolis, IN 46204-4288

A copy of the *1099* in question and any documentation supporting the requested change is required.

The Finance Unit must receive requested changes no later than March 1 to issue a corrected *1099.* If the Finance Unit determines that a corrected *1099* should be issued, it issues a new *1099*, if the request was received by March 1. When information has been filed with the IRS (by March 1), all corrections are updated in the provider's file and used for future reporting to the IRS.

B-Notice Process

The *B-Notice* is a letter indicating that the name and tax ID a provider submitted on the *W-9* was incorrect, according to IRS records.

Twice a year, in the spring and in the fall, the IRS compares the tax ID and the name supplied by DXC to IRS records. If the taxpayer name and number combination do not match, the IRS notifies DXC, and the Finance Unit generates a *B-Notice*.

For the first *B-Notice*, the notice, a blank *W-9*, and a self-addressed envelope are mailed to the provider's home office (legal) address with instructions for completion. If a provider receives a second *B-Notice* within 3 calendar years, the notice requires the provider to obtain a *147C* form by contacting the IRS or the Social Security office. **Both types of *B-Notices* include a deadline for documentation to be completed and received by the Finance Unit**. If the Finance Unit does not receive the documentation by the date shown on the *B-Notice*, DXC is required to begin backup withholding from the provider's payments.

Backup Withholding

Backup withholding is the process DXC uses to forward the required percentage (set by the IRS) of the provider's net payment to the IRS as a tax payment. The amount withheld is forwarded to the IRS weekly and is tied to a specific tax ID. These amounts appear on the provider's *1099*.

If a provider is subject to backup withholding, the *Payments to Lien Holders* section on the last page of the RA (see Figure 22) will list **Withholding** under Lien Holder Name, with the amount withheld as the Lien Amount.

DXC can stop backup withholding only after receiving the required documentation from the provider. Required documentation can be mailed to the following address:

Financial Analyst
DXC Finance Unit
1099 Processing
950 N. Meridian St., Suite 1150
Indianapolis, IN 46204-4288

> *Note: DXC cannot refund money that has been withheld from a provider and forwarded to the IRS.*

It is imperative that providers receiving a *B-Notice* from DXC respond promptly with the appropriate documentation stated in the *B-Notice* to avoid backup withholding.